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# THE CONTINUING INFANT MORTALITY CRISIS IN ILLINOIS PART 1

## HEARING

BEFORE THE

## SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

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HEARING HELD IN SPRINGFIELD, IL, OCTOBER 5, 1987

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# CONTENTS


| | Page |
|---|---|
| Hearing held in Springfield, IL, October 5, 1987 | 1 |
| Statement of: | |
| Dunn, Barbara Burke, executive director, Community Health Improvement Center, Decatur, IL | 172 |
| Eisenstein, Sharon A., director of social services, Southern Seven Health, Department; program director, Parents Too Soon program, Ullin, IL | 137 |
| Fesco, Edward J. M.D., president, Illinois State Medical Society, La Salle, IL | 161 |
| Fraed, Cynthia, M.D., obstetrician and gynecologist, Harrisburg, IL | 111 |
| Landis, Sandra, executive director of Planned Parenthood, Springfield area, Springfield, IL | 130 |
| Pitsenberger, Ann, O.S.F., executive vice president, St. John's Hospital, Springfield, IL | 92 |
| Reardon, Joan, counselor, Care Center of Springfield, Inc., Springfield, IL. | 101 |
| Rynders, Lynn, parent, Springfield, IL | 8 |
| Singleton, James, M.D., obstetrician, Springfield, IL | 156 |
| Turnock, Bernard J., M.D., director of public health, State of Illinois | 17 |
| Velazquez, Myriam, parent, Springfield, IL; presented by Jamie C. Hickman, program director, WIC program; Springfield Urban League | 13 |
| Prepared statements, letters, supplemental materials, et cetera: | |
| Bodewes, Carolyn, project director, Care Center of Springfield, Inc., Springfield, IL, prepared statement of | 108 |
| De Land, Brent H., Ph.D., executive director, Illinois Community Action Association and Adjunct Associate Professor, Sangamon State University, Springfield, IL, prepared statement of | 186 |
| Diekroeger, James L., director of public health, Springfield Department of Public Health, Springfield, IL, prepared statement of | 183 |
| Dunn, Barbara Burke, director of the Community Health Improvement Center, Decatur IL, prepared statement of | 176 |
| Durbin, Hon. Richard J., a Representative in Congress from the State of Illinois, prepared statement of | 6 |
| Eisenstein, Sharon A., director of social services, Southern Seven Health Department; program director, Parents Too Soon program, Ullin, IL, prepared statement of | 141 |
| Fesco, Edward J., M.D., president, Illinois State Medical Society, La Salle, IL, prepared statement of | 163 |
| Fraed, Cynthia, M.D., board-certified obstetrician and gynecologist, Harrisburg, IL, prepared statement of | 113 |
| Grimes, David L., M.D., obstetrics and gynecology, letter to Jane Wernsmen, director of nursing, Southern Seven Health Departments, dated July 22, 1987 | 146 |
| Landis, Sandra M., executive director, Planned Parenthood, Springfield area, Springfield, IL, prepared statement of | 133 |
| Miller, Hon. George, a Representative in Congress from the State of California, and chairman, Select Committee on Children, Youth, and Families: | |
| Prepared statement of | 2 |
| "The Continuing Infant Mortality Crisis In Illinois" (a fact sheet) | 3 |
| Pitsenberger, Sister Ann, O.S.F., executive vice president, St. John's Hospital, Springfield, IL, prepared statement of | 95 |
| Reardon, Joan, counselor, Care Center of Springfield, IL, statement of | 103 |
| Rynders, Lynn, parent, Springfield, IL, prepared statement of | 10 |

Page

Prepared statements, letters, supplemental materials, et cetera—Continued
Singleton, James, M.D., obstetrician, Springfield, IL, prepared statement of ..... 158
Sutton, Julia, CRNA, Springfield, IL, prepared statement of ..... 203
Turnock, Bernard J., M.D., director of public health, State of Illinois:
Birth Certificate Survey on Access to Prenatal and Well Child Care.... 64
Human Services Plan, 1988, Part I—Data Report, Vol. 7 ..... 53
Infant Mortality Appropriations (Table I) ..... 52
"Infant Mortality Reduction In Illinois: An Overview" ..... 22
Velazquez, Myriam, Springfield, IL, prepared statement of ..... 15

# THE CONTINUING INFANT MORTALITY CRISIS IN ILLINOIS

## Part 1

MONDAY, OCTOBER 5, 1987

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES,
*Springfield, IL.*

The select committee met, pursuant to notice, at 9:20 a.m., in the Centennial Room, St. John's Hospital, 800 East Carpenter Street, Springfield, IL, Hon. George Miller presiding.

Members present: Representatives Miller, Durbin, and Hastert.

Staff present: Ann Rosewater, staff director; Jill Kagan, professional staff; and Evelyn Anderes, minority staff assistant.

Chairman MILLER. The committee will come to order. Today is National Child Health Day, and while the White House is sending up balloons and signing proclamations, the Select Committee on Children, Youth, and Families is here to examine why the most preventable national tragedy, the annual death of 40,000 babies in their first 12 months of life, continues to occur.

Thanks to my colleague, Congressman Richard Durbin, we have come to Springfield this morning and we will travel to Chicago this afternoon. I would like to thank my colleague, Dennis Hastert, for joining us this morning to examine the persistently high rates of infant death in this State.

Few indicators of a nation's health are more important than infant mortality. But after years of reducing infant deaths—and low birthweight, a leading determinant of neonatal death and disability—in the 1980's our progress has come to a virtual standstill.

In Illinois there have been several exemplary State, local, and private initiatives to improve infant health. Yet, infant mortality and low birthweight rates remain above the national average, and higher than any other northern industrialized State. For black infants in Illinois, as well as throughout the Nation, the risks of infant mortality and low birthweight are twice as high.

What I find most disturbing is that a great many infant deaths, and in fact, a great many problems in early childhood, could be prevented through early and continuing prenatal care. Yet an alarming number of women, especially those who are uninsured, low-income, or teenagers, fail to receive such care.

Since 1979, the percentage of pregnant women receiving prenatal care in the critical first trimester, 76 percent, has seen no marked improvement. A just-released General Accounting Office survey of

pregnant women, both Medicaid recipients and uninsured women, concluded that insufficient prenatal care was a problem for women of all childbearing ages, of all races, and from all sizes of communities. The GAO found that in Illinois and seven other states surveyed nearly two-thirds of the women received insufficient prenatal care last year.

Stopping these tragedies makes fiscal as well as human sense. From my perspective, the chance to spend $400 for comprehensive prenatal care over the 9-month course of pregnancy for a healthy baby instead of $20,000 for 20 days of neonatal intensive care for an underweight baby is an opportunity not to be missed. The evidence is clear. We can return $3 to the Federal treasury for every $1 we invest in nutrition supplements for high risk pregnant women and more than $3 for every $1 we invest in prenatal care.

While we know that prenatal care significantly reduces infant mortality and low birthweight, we have yet to learn why so many women are unable to obtain this care. We will hear this morning from health care providers, state and local health officials, advocates, and mothers who have had difficulty in obtaining appropriate prenatal care. It is my hope that their testimony will help us determine how the federal, state, and local governments, working together with the private sector, can overcome the barriers to care and ensure a healthy start for all children.

Let me thank St. John's Hospital for their hospitality and for the opportunity to hold our hearings, and for the tour they gave us this morning of their critical nursery facilities. I also appreciate the excellent cooperation we have received from the Governor's Office in planning these hearings today.

OPENING STATEMENT OF HON. GEORGE MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA, AND CHAIRMAN, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

Today is national Child Health Day. And while the White House is sending up balloons and signing proclamations, the Select Committee on Children, Youth and Families is here to examine why a most preventable national tragedy—the annual death of 40,000 babies in their first 12 months of life—continues to occur. Thanks to my colleague, Congressman Richard Durbin, we have come to Springfield this morning, and we will travel to Chicago this afternoon, to examine the persistently high rates of infant death in this state.

Few indicators of a nation's health are more important than infant mortality. But after years of reducing infant deaths—and low birthweight, a leading determinant of neonatal death and disability—in the 1980's our progress has come to a virtual halt.

In Illinois, there have been several exemplary State, local and private initiatives to improve infant health. Yet, infant mortality and low birthweight rates remain above the national average, and higher than any other northern industrialized state. For black infants in Illinois, as well as throughout the nation, the risks of infant mortality and low birthweight are twice as high.

What I find most disturbing is that a great many infant deaths—and, in fact, a great many problems in early childhood—could be prevented through early and continuing prenatal care. Yet an alarming number of women, especially those who are uninsured, low-income, or teenagers, fail to receive such care.

Since 1979, the percentage of pregnant women receiving prenatal care in the critical first trimester—75 percent—has seen no marked improvement. A just-released Government Accounting Office survey of pregnant women—both Medicaid recipients and uninsured women—concluded that "insufficient prenatal care was a problem for women of all childbearing ages, of all races, and from all sizes of communities." And GAO found that, in Illinois and the 7 other states surveyed, nearly two-thirds of the women received insufficient prenatal care last year.

Stopping these tragedies makes fiscal as well as human sense. From my perspective, the chance to spend $400 for comprehensive prenatal care over the 9 month course of pregnancy for a healthy baby instead of $20,000 for 20 days of neonatal intensive care for an underweight baby is an opportunity not to be missed. The evidence is clear: we can return $3 to the Federal Treasury for every one we invest in nutrition supplements for high risk pregnant women, and more than $3 for every one we invest in prenatal care.

While we know that prenatal care significantly reduces infant mortality and low birthweight, we have yet to learn why so many women are unable to obtain this care. We will hear this morning from health care providers, state and local health officials, advocates, and mothers who have had difficulty obtaining appropriate prenatal care. It is my hope that their testimony will help us determine how the federal, state and local governments, working together with the private sector, can overcome the barriers to care and ensure a healthy start for all children.

Let me thank St. John's Hospital for their hospitality and for the opportunity to hold our hearing here. I also appreciate the excellent cooperation we have received from the Governor's office in our planning of these hearings.

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## The Continuing Infant Mortality Crisis in Illinois—A Fact Sheet

### INFANT MORTALITY RATE CRITICALLY HIGH; ILLINOIS AMONG NATION'S HIGHEST

The U.S. ranked last (tied with Belgium, the German Democratic Republic and the German Federalist Republic) among 20 industrialized nations in its infant mortality rate (IMR) [1] in 1980–85. (Children's Defense Fund [CDF], 1987)

In 1985, there were 40,030 deaths of infants under 1 year nationwide, an IMR of 10.6. For white infants, the rate was 9.3, essentially the same as in 1984; for black infants, the rate was 18.2, compared with 18.4 in 1984. (National Center for Health Statistics [NCHS], 8/87)

Neonatal mortality rates (NMR) [2] for all infants were essentially the same in 1984 and 1985 (7.0); postneonatal mortality rates (PNMR) [3] for white infants were about the same in 1985 (3.2) as in 1984 (3.3), continuing a 3-year pattern. For black infants, the PNMR declined between 1984 (6.5) and 1985 (6.1), continuing the decline observed from 1983 (6.8) to 1984. The downward trends in the NMR and PNMR have slowed recently for infants of both races. (NCHS, 8/87)

With the exception of Illinois, the 10 States with the highest overall IMR's in 1984 were all southern (DC, SC, MS, AL, GA, NC, VA, LA, and TN). (CDF, 1987)

In 1986, Illinois had an IMR of 12.0, up from 11.6 the previous year. In 1984, the IMR for blacks (20.4) in Illinois was more than twice as high as that for whites (9.4). (Illinois Department of Public Health [IDPH], 1987)

### LOW BIRTHWEIGHT RATE PLATEAUS; REMAINS STRONG PREDICTOR OF INFANT MORTALITY

Low birthweight (LBW) [4] infants in the U.S. are nearly 40 times more likely to die in the 1st month of life and are 3 times more likely to have neurodevelopmental handicaps and congenital anomalies than normal infants. (Institute of Medicine [IOM], 1985)

In 1985, 67% of infant deaths during the 1st month and 50% of deaths in the 1st year of life were attributable to LBW. (Government Accounting Office [GAO], 9/87)

In 1985, 6.8% of all live births (about 254,000 babies) were LBW, the same rate as in 1980. In Illinois, the proportion of LBW infants rose from 7.2% in 1982 to 7.5% in 1986. (GAO, 9/87; IDPH, 1987)

The proportions of very LBW [5] infants were higher in 1984 than in 1978 for both white and black infants. (NCHS, 12/86)

Of the babies born to Medicaid recipients and uninsured women recently surveyed by GAO, 12.4% were LBW. (GAO, 9/87)

Babies born to women who receive no prenatal care are 3 times more likely to be of LBW than those born to mothers who receive early care. (GAO, 9/87)

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[1] Infant mortality rate (IMR) = deaths to infants under 1 year/1,000 live births.
[2] Neonatal mortality rate (NMR) = deaths to infants under 28 days/1,000 live births.
[3] Postneonatal mortality rate (PNMR) = deaths to infants 28 days–11 months/1,000 live births.
[4] Low birthweight (LBW) 5½ lbs. (2,500 grams) or less at birth.
[5] Very low birthweight (LBW) = under 3 lbs, 3 oz (1,500 grams) at birth.

### INFANT MORTALITY, LOW BIRTHWEIGHT MORE LIKELY AMONG BABIES OF TEENAGE MOTHERS

Infants born to teenage mothers are 60% more likely to die in the neonatal period and about twice as likely to die in the postneonatal period as those born to mothers over age 20. These infants are 2-3 times as likely to be LBW as infants born to mothers in their 20's or 30's. (Congressional Research Service, 1/86)

In 1984, 13% of all births were to teenagers. 13.6% of mothers under 15, 10.3% of mothers ages 15-17 and 8.8% of mothers ages 18-19 had LBW infants. (NCHS, 7/86; Select Committee on Children, Youth, and Families [CYF], 3/87)

In 1985, 12.5% of births in Illinois were to teenage mothers, 10.7% of whom had late prenatal care and 10.3% of whom had LBW infants. (IDPH, IL County Area Rates and Rankings, 1985)

While the average annual IMR among all Illinois women between 1982-84 was 10.0, it was 21.5 among 15-17 year olds and 17.4 among 18-19 year olds. (CYF, 12/85)

### SMOKING AND ALCOHOL ABUSE PLACE INFANTS AT RISK OF DEATH; LOW BIRTHWEIGHT

In the U.S., maternal smoking results in roughly 50,000 fetal deaths and 4,000 infant deaths each year; about 36,000 (15%) LBW babies born in 1983 were underweight because their mothers smoked during pregnancy. (CYF, 5/86)

Between 3,700 and 7,400 babies were born with fetal alcohol syndrome (FAS) in 1982; 80% of children with FAS have pre- and postnatal growth retardation requiring neonatal intensive care. (CYF, 5/86)

### PRENATAL CARE REMAINS UNAVAILABLE TO MANY

From 1979-1985, the proportion of mothers who did not begin prenatal care in the critical first trimester of pregnancy remained stagnant at 24%. 21% of white mothers and 38% of black mothers in 1985 did not receive early prenatal care. (NCHS, 7/87)

In Illinois, while there was a slight improvement in the proportion of women receiving prenatal care in the first trimester from 77% in 1982 to 78% in 1986, the percentage of women with very late or no care increased (4.3% in 1982 compared with 4.7% in 1986). (IDPH, 1987)

Approximately 11,400 low income women who receive late or no prenatal care deliver babies in Illinois each year. (Voices for Illinois Children, 8/87)

Nearly 63% of Medicaid recipients and uninsured women (69% of low-income teens) and 29% of women with private health insurance surveyed by GAO, received insufficient prenatal care. 16% of Medicaid recipients and 24% of uninsured women surveyed (but only 2% of privately insured women) began prenatal care during the last 3 months of pregnancy or made 4 or fewer visits. (GAO, 9/87)

In 1984, 17% of women of reproductive age lacked insurance to pay for prenatal care and another 9% had only Medicaid coverage. (GAO, 9/87)

In 1986, the average Medicaid reimbursement rate for total maternity care was about $473 nationwide and $446 in Illinois, while the median physician charge for such care was more than twice as high ($1,000). (GAO, 9/87)

A 1985 survey indicated that obstetricians/gynecologists (ob/gyn's) paid an average of $20,818 for insurance coverage in 1984. The mean cost of coverage in the Mid North region, which includes Illinois, was $23,025, or 11.1% of mean gross income. For those reporting increases, premiums had risen an average of $9,871 since 1983, and an average of $13,361 in the Mid North region. (American College of Obstetgricians and Gynecologists [ACOG], 11/85)

As of 1985, 12.3% of ob/gyn's nationwide had given up obstetrics due to liability pressures. 23.1% had decreased the level of high risk obstetrical care and 13.7% had decreased the number of deliveries they performed. (ACOG, 11/85)

In 1984, an estimated 40% of high-risk pregnant women and children eligible for the Supplemental Food Program for Women, Infants and Children (WIC) were served; less than half (48%) of eligible Illinois women and children were served. (U.S. Department of Agriculture [USDA], 1987; CDF, 1987)

### PRENATAL CARE, PROPER NUTRITION PROMOTE INFANT HEALTH, SAVE PUBLIC DOLLARS

A woman who has 13-14 prenatal visits has only a 2% chance of having a LBW baby. Without any prenatal care, the risk is over 9%. (GAO, 9/87)

WIC participation leads to longer pregnancies, leading to fewer premature births, and fewer fetal and neonatal deaths. For every $1 invested in WIC's prenatal com-

ponent, as much as $3 are saved in short-term hospitalization costs. (USDA, 1/86; CYF, 8/85)

Every $1 spent on prenatal care for high-risk women could save $3.38 in the cost of neonatal intensive care, on which more than $2.4 billion is spent annually. (IOM, 1985; GAO, 9/87)

Chairman MILLER. At this point I would like to recognize my colleague, Congressman Durbin.

Mr. DURBIN. Thank you. I want to thank my chairman, Congressman George Miller. Most of us only take a short flight to get where we are going but George comes all the way from California. So it was a special effort for him to be here this morning.

I also want to thank my colleague, Dennis Hastert, who got up very early this morning to drive down from his home in northern Illinois to join us at this hearing.

Let me echo, too, the appreciation and gratitude which we have for St. John's Hospital and its dedicated staff. They have bent over backward to make this hearing a success and they gave us a short tour this morning of a facility that I had seen before, but it really opens your eyes to the fact that what we are talking about here is a life and death struggle.

As George Miller has mentioned to you, the statistics are appalling in a nation that has the resources of the United States of America when it comes to infant mortality. In the 1950's the United States was ranked sixth of 20 industrialized countries around the world in terms of infant mortality. We are now ranked twentieth. We are dead last and there is absolutely no excuse for it.

When you consider the variables that we will be talking about today you will undoubtedly hear of the heroic struggles that are taking place at St. John's Hospital and many other facilities across Illinois and across the nation to save these tiny babies. We saw evidence of it this morning. And it is dramatic to think of the helicopter rescues, in fact, that bring these tiny babies no longer than the palm of your hand upstairs to the ninth floor for the kind of intensive care they need to survive. And the efforts of the medical staff, the doctors and the nurses and all of the folks involved in these hospitals, around the clock, to find the best medical technology, the best research, and to try to find any way possible to save that baby's life. It is absolutely a heroic life and death struggle.

What we are going to talk about, too, is another aspect of the problem that is equally important though it may not sound as heroic, the very basics, that a mother who is pregnant in downstate Illinois or anywhere in this country has a chance to see a doctor during her pregnancy; something that basic. And to make sure that that mother has the information about how necessary prenatal care is, and that her child benefits from the nutrition and the care which can be given to a mother who is closely monitored during her pregnancy.

These things are not quite as heroic but frankly, when you look at the end result, a healthy baby, they produce the result that we are looking for.

We have talked this morning upstairs in the neonatal intensive care unit to Dr. Zeftekhari about the problems that he has encountered. Ladies and gentleman, if there is one statistic that I think tells the story about why we are here today, it is the fact that over

8 percent of the population in Illinois may qualify as Medicaid recipients. Sixty percent of the children who go into the neonatal care center upstairs are the children of Medicaid recipients. We are not providing the type of care that we should to the poor, the indigent, and the uninsured. And quite frankly we are paying the price. In the "isolettes" upstairs these children struggle to survive and as Congressman Miller said, at great expense to us as taxpayers.

I think there is a compelling human story here; but there is a compelling economic story here. If we make that initial investment that the mother has a healthy, safe pregnancy and the baby is born and can survive, we have done something we should do to our fellow people in this country, but we have also done something that is absolutely essential to save the limited resources which we have available. Caring for each child in the neonatal care center upstairs costs about $1,000 a day, and most children are in there about 22 days, according to the doctors upstairs, $22,000, while we and the State of Illinois compensate the obstetrician for care of the child with about $450, about half of what the actual expense is. So I think we see that we need an investment here and I hope our witnesses will lead the way to find some solutions for this important process.

This national crisis clearly requires our communities, local, State, and Federal governments to work together in order to turn the trend around. We really owe it to our children, the chance to begin a happy and healthy life.

[Opening statement of Hon. Richard J. Durbin follows:]

OPENING STATEMENT OF HON. RICHARD J. DURBIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

First of all, I would like to take this opportunity to thank Chairman Miller and the Select Committee on Children, Youth, and Families for holding this important field hearing. I would also like to thank the dedicated staff here at St. John's Hospital for all their assistance in helping prepare for the hearing.

It is our aim today to explore some of the many factors that have contributed to the infant mortality crisis and barriers to prenatal care. I look forward to hearing testimony from our distinguished witnesses and thank all of you for joining us.

The U.S. infant mortality rate is a national crisis that extends far beyond local and state boundaries. Progress in reducing infant mortality in this country has come to a virtual standstill. America's infant mortality ranking among 20 industrialized nations has declined dramatically from sixth to a tie for last place. As our medical technology advances, our success rate in keeping babies alive is deteriorating at a shameful pace. Illinois is in the unfortunate position as one of the ten states with the highest infant mortality rate in the country. Illinois' low birth rate is also above the national average.

The National Academy of Sciences has estimated that low-birthweight infants are 40 times more likely to die in the first year than other infants, and face a much greater risk of developing serious health problems and disabilities. The key to insuring the birth of a healthy baby is prenatal care. Pregnant women who receive no prenatal care are three times more likely to deliver a low birthweight baby than women who see a doctor early and regularly during their pregnancy. With good prenatal care, low birthweight births could be reduced by up to 15%, and an even higher percentage of birth defects could be prevented.

Earlier this morning, we visited the neonatal intensive care unit here at St. John's hospital. While amazing advances in technology have allowed us to keep these tiny infants alive, they may be faced with long-term disabilities and may require special educational and social services throughout their lifetime. Caring for each child in a neonatal I.C.U. costs an average of $1,000 a day. More than $2.5 billion is spent annually on neonatal intensive care services in the United States.

These are shocking figures in light of the estimates that every dollar spent on prenatal care can save $3 in the cost of caring for a low birthweight infant. Yet frequently in this country, we are finding women are not getting the prenatal care essential for delivery of a healthy infant.

This national crisis clearly requires that our communities and our local, state and federal governments work together in order to turn the trend around. We owe our children a chance to begin a healthy, happy life.

Chairman MILLER. I would like at this point to recognize Congressman Hastert.

Mr. HASTERT. Thank you, Mr. Chairman. I certainly appreciate the invitation to attend with you today.

We are talking about an issue that is emotional, it is something of the basic welfare of the children of this state, and it also has ties to, unfortunately, economics and politics. We hope that through the testimony today of those people who come forward and talk, we can begin to see the keys of how we can help solve the problem. If it is a problem that could be solved with more dollars, if it is a problem that may be solved with more helping hands, more people to be able to participate. We also want to look at the issues that are underlying this problem, the issue of those people who have the very key to be able to help, that are being threatened in the very practices involved in the process, and we need to take a look at the key to the politics of this and try to find some type of a resolution. So I appreciate the opportunity to be with you here today, Chairman Miller, and hope that we can move to the resolution of this.

Chairman MILLER. Thank you. And at this point I would like to recognize Al Laabs, who is the Administrator here at the hospital, for some remarks.

Mr. LAABS. Good morning. I would like to welcome all of you to this hearing conducted by the Select Committee on Children, Youth, and Families. We are delighted to be able to host this event for a very special reason. This is also National Respect Life Week, and our heritage as a hospital calls us to defend life, the life of the very old and the life of the very young, and for that reason this is indeed a good time for us to host this.

We hope that your hearing will be successful and as we do with all significant events at St. John's Hospital, we ask that God will be present to us and that his spirit will give us the insight we need to find answers to this very difficult and trying problem of infant mortality.

Again, welcome to St. John's.

Chairman MILLER. Thank you. And again, let me thank my two colleagues, Dennis and Dick, for helping us put together this hearing. They have been absolute stalwarts on this Select Committee on Children, Youth, and Families. Dennis brings a long legislative involvement in a number of the issues that we are concerned with, with his service at the state legislature, and Dick has been, to put it politely, more than helpful on the Appropriations Committee in getting that committee to understand, as he pointed out, the need for us to make some of these investments now to avoid future tragedies. And I think that when we are done with this entire day, this committee will be much richer, and hopefully wiser in trying to produce additional solutions to this national tragedy that is clearly, to a great extent, avoidable.

We need to be out of this room by 11:30 because the committee is having the second half of this hearing in Chicago this afternoon. We have two panels and I would just like the panelists to be aware of that. Because obviously you get more questions than you can possibly handle from the committee side of the table. So to the extent that panelists would summarize their statements would be deeply appreciated so that we can make sure not to get into the situation where we have to so abbreviate the final witnesses and not receive the full benefit of their testimony. So we will try to divide the panels equally, to make sure.

I would also say that for people in the audience, if you listen to the testimony this morning, if you think that you have some information or you want to take issue with what is said here, or you have something that you think will be beneficial to the committee, we would certainly welcome your making that available to us. Just write to the Select Committee on Children, Youth, and Families, House of Representatives, Washington, DC, and we will make it a part of the file of this hearing. So we certainly encourage you to do that.

Obviously we do not have the ability to hear from everybody who seeks to testify but we do try to continue to gather that information. You can send it to us or to either of my colleagues' offices.

The first panel today will be made up of Lynn Rynders who is a parent from Springfield, IL. Our second member of the panel was Myriam Velazquez, but Myriam had her baby today so she is not going to be here. I have always said these pregnancies would not wait for politics. So Jamie Hickman, Director of the Springfield Urban League WIC, will read Myriam's testimony in her absence.

Then we will have Dr. Bernard Turnock who is the director of the Illinois Department of Public Health; Sister Ann Pitsenberger, who is the executive vice president of St. John's Hospital; Joan Reardon who is a counselor for the Care Center in Springfield, who will be accompanied by Carolyn Bodewes, who is a project director of the Care Center; and Dr. Cynthia Fraed who is an obstetrician from Harrisburg, IL.

If you will come forward to the witness table, we will take your testimony in the order in which I read your names. And we welcome you to the committee and appreciate you taking your time. And, Sister Pitsenberger, we certainly thank you for the use of these facilities and for the help that you have given the committee in setting up these hearings.

This is a pretty relaxed committee so we will have you proceed in the manner in which you are most comfortable. Your entire written statement and documents will be placed in the record in their entirety. You may proceed through your statement in the manner which you desire. Ms. Rynders.

## STATEMENT OF LYNN RYNDERS, PARENT, SPRINGFIELD, IL

Ms. RYNDERS. In September 1984 I realized I was pregnant, and my husband and I had no insurance at this time. So we could not afford it, as he was a barber stylist. So I went to Public Aid to apply for a medical card and we were given a huge spenddown which there was no way we could meet.

I tried to get my doctor to see me because I knew that prenatal care was important. Talking to the receptionist I was informed that I would have to come up with $75 for an initial fee, and each time I saw the doctor I would have to have this amount of money, I told her at this point in our life there was no way I could come up with this much money. And she said, well, call us back when you get the money.

I ended up making several phone calls to several different doctors in the community and was told the same thing: when you have the cash, come in. At this point I decided, well, I can make it through my pregnancy without a doctor's care. After all, women did it years ago. And I was nutritious-conscious, and I figured I knew how to take care of myself.

Unfortunately, my health started to deteriorate. I am an asthmatic and I started to have a lot of chronic asthma problems. When it got so bad, my husband took me to the hospital. The doctor there insisted that I had to get care somehow, because I was losing so much oxygen I was turning blue and obviously the baby was not getting the air either.

So I had heard about the Care Center on the radio and contacted them. Through the Care Center I was able to get treatment at a doctor's office, but it was—excuse me.

I was able to see a doctor when I was 4 months pregnant, and after that I saw the resident every month. And I saw a different resident several times. And at this point I was really grateful that I was getting some kind of help. But when I had problems I needed to see a physician. I did not feel comfortable with a resident at that point, but it did not matter because since I was on Public Aid —oh, no. I was not on Public Aid at that time. The Care Center was paying for it. They informed me I had to see the resident. So I just accepted that. It was something out of my control.

[Pause.]

After the baby was born there were complications, and it was then that we were able to get Public Aid to come in and help us. And they did take over the hospital bills then. If I had not had the Care Center to help me, and prenatal care, she probably would not have made it.

[Pause.]

I'm sorry.

Chairman MILLER. If you would like to take a minute we can go on to Ms. Hickman and have her testify and you can——

Ms. RYNDERS. Thank you.

Ms. HICKMANN. Do you want me to go next?

Chairman MILLER. Yes. Why not do that?

[Prepared statement of Lynn Rynders follows:]

PREPARED STATEMENT OF LYNN RYNDERS, PARENT, SPRINGFIELD, IL

In September of 1984, I realized I was pregnant and unfortunately, my husband and I had no insurance. I had been out of work since December of 1983, and my husband was a barber stylist with a fast failing business. There was no way we could afford health insurance and now we were faced with unexpected medical bills. We couldn't get help from Public Aid as they set a hugh monthly spenddown because my husband had a job.

Knowing how much doctors and health care personnel stress pre-natal care, I called my gynecologist to make an appointment. The receptionist informed me the maternity fees had to be paid before delivery and on my initial visit I would need to pay $75.00. When I told the receptionist I couldn't even come up with $25.00 right now, she told me to call back when I had the $75.00.

After that I made several other phone calls to area gynecologists and each office told me the same thing. I then decided I could go through my pregnancy without a doctor as I was nutritious conscious and in fairly good physical condition. I also figured when it was time to deliver, the hospital would have to help me.

Unfortunately, my health didn't hold. About a month later, my asthma started acting up and I began having severe

attacks daily. Because I was pregnant my allergist didn't want to medicate me and since I had no gynecologist I had to rely solely on my allergist.

I continued having severe asthma attacks for another month and suffering tremendously. I felt so terrible I wanted to ~~die---~~I just wasn't up to going through the rest of my pregnancy in that condition.

One night, around Thanksgiving, I had an attack that was so bad my husband forced me to go to the hospital for emergency treatment. The emergency room doctor told me he wanted to keep me in the hospital I was in such bad condition. He was really concerned because my extremities were turning blue.I convincedhim to let me go home after treatment and he in turn convinced my allergist to give me appropriate medication. He also told me I needed to get a gynecologist right away but had no suggestions as to who would treat someone in my financial condition.

After the hospital episode I began to feel somewhat desperate. Earlier in my pregnancy I remembered hearing an advertisement directed to young mothers in need of pre-natal care. However, I felt anything but young so I didn't even catch the name of the place or the phone number. Now I felt so desperate, I decided I had to find out where this place was and see if I could get help even if I wasn't young. We finally heard the advertisement again, and I immediately called the Care Center.

I talked to Joan Reardon for the first time than and she informed me I wasn't "too old" to come to the Care Center for help. She set up an appointment to see me within a couple of days. On my first visit there, she arranged for me to see a doctor that same afternoon. I was told I would be seeing a resident for the duration of my pregnancy, but at this point I was just grateful to get some help. I wasn't particulary happy with all the residents I saw, but I had no choice in the matter.

In fact, I was so unhappy with the last resident I saw I wouldn't go back for my annual checkup because the receptionist wouldn't let me see anyone other than a resident.

This Spring I had a problem I couldn't tolerate much longer and my regular physician suggested I see a certain doctor in a particular gyn group. But when I called to make an appointment, I was told I had to see a resident. After my previous experience, I wasn't too happy, but once again I felt I had no choice.

This time I was fortunate to have a wonderful doctor who was just finishing her residency and about to set up her practice in this same medical group. I had some problems after surgery and when I needed to see my doctor, I was told I had to see the new resident. My doctor told me she was transferring me to her private practice but I had to practically fight with the receptionist in order to see her.

Lynn Rynders

**STATEMENT OF MYRIAM VELAZQUEZ, PARENT, SPRINGFIELD, IL; PRESENTED BY JAMIE C. HICKMANN**

Ms. HICKMANN. As everybody was informed, I am not Myriam Velazquez. My name is Jamie Comerford Hickmann and I am the program director with the WIC Program for the Springfield Urban League.

Myriam is one of the clients on our program, and she so desperately wanted to be here today, but her little one did not exactly cooperate. She did actually have the baby September 30. She had to take the baby back in to the doctor. She is a breastfeeding mother and the baby was a little jaundiced so they may have to put her back in the hospital. I did talk to her a few minutes before and just asked her if I could go ahead and read her testimony, and she was really very positive about it and wanted me to make sure that people knew how she felt. So I am going to be reading what it is that she dictated to me Friday afternoon while she was in the hospital. And bear with me if I mess up here a little bit.

[Ms. Hickmann then read the following statement:]

Good morning, my name is Myriam Velazquez. I am 20 years old and currently living in Springfield with my new baby daughter, Jazzray Karla Faychon Velazquez. Karla was born on September 30. Since Karla was about a week early I requested permission from my doctor to come and testify today. I am here to talk about the importance of prenatal care and its impact on the health of the infant.

I would like to talk about my personal situation. I was six months pregnant when I was kicked out of my house due to the pregnancy. I had no prenatal care before being kicked out and then had no insurance or money for such care. I applied for a medical card in June in Chicago Heights and it was approved. At that time I came to Springfield to live with a friend who had a room for me. The medical card was sent to Chicago Heights and forwarded to Springfield in mid-July.

It was at this point I started looking for doctors through the phone book. I called about 10 doctors and none would accept the medical card, nor could they tell me of other doctors that did take the medical card. I finally got through to SIU Family Practice Center. They told me they accepted the medical card but had a 65-person waiting list. I told them that I was seven months pregnant. They said it was the best they could do, so I asked to go ahead and be put on the waiting list.

A few days later I went back to the phone book and found a number for help in finding doctors. I called and was given a number for SIU Memorial Medical Center. That is how I got to Dr. Kauffman who saw me the next day. He told me it would have been better if I had seen a doctor earlier in my pregnancy.

He diagnosed that I had gestational diabetes and was anemic. I had to go back one time per week for tests from the first visit on. I was also seeing Dr. Sandy Eardly, a registered dietitian, who told me to call and get on the WIC Program.

I called the Springfield Urban League WIC Program and with the referral from Sandy was on the program within 2 weeks.

I feel that prenatal care is so important because after receiving such good care I learned that complications could arise at any time during my pregnancy that could affect me and my baby. I am so lucky I did not have any problems due to the good care I received from everyone at Memorial Medical Center.

I would like to thank the Springfield Urban League WIC Program for thinking of me as a participant in these hearings. I would also like to say thank you to Congressman Durbin and his staff, for letting me be a part of this today. Thank you for your time.

[End of Ms. Velazquez' statement.]

Just for your information, Karla was 6 pounds and 13 ounces.

[Prepared statement of Myriam Velazquez follows:]

## PREPARED STATEMENT OF MYRIAM VELAZQUEZ, SPRINGFIELD, IL

*Good morning, my name is Meriam Velazquez, I am 20 years old and currently living in Springfield with my new baby daughter, Jazzray Karly Faychon Velazquez. Karla was born on September 30th. Since Karla was about a week early, I requested permission from my doctor to come and testify today. I am here to talk about the importance of prenatal care and its' impact on the health of the infant.*

*I would like to talk about my personal situation. I was 6 months pregnant when I was kicked out of my house due to the pregnancy. I had no prenatal care before being kicked out and then had no insurance or money for such care. I applied for a medical card in June in Chicago Heights and it was approved. At that time I came to Springfield to live with a friend who had a room for me. The medical card was sent to Chicago Heights then forwarded to Springfield in min-July. It was at this point I started looking for doctors through the phone book. I called about 10 doctors and none would accept the medical card. Nor could they tell me of other doctors that did take the medical card. I finally got through to the SIU Family Practice Center, they told me they accepted the medical card but had a 65 person waiting list. I told them that I was 7 months pregnant, they said it was the best they could do, so I asked to be put on the waiting list.*

*A few days later, I went back to the phone book and found a phone number for help in finding doctors. I was given a number for SIU Memorial Medical Center. That is how I got to Dr. Kauffman who saw me the next day. He told me that it would have been better if*

I had seen a doctor earlier in my pregnancy. He diagnosed that I had gestational diabetes and was anemic. I had to go back one time per week for tests from the first visit on. I was also seeing Dr. Sandy Eardly, a registered dietitian. She told me to call and get on the WIC Program. I called the Springfield Urban League WIC Program and with the referral from Sandy was on the program within two weeks.

I feel that prenatal care is so important because after receiving such good care, I learned that complications could arise at any time during my pregnancy that could effect me and my baby. I am so lucky I did not have any problems due to the good care I received from everyone at Memorial Medical Center.

I would like to thank the Springfield Urban League WIC Program for thinking of me as a participant in these hearings. I would also like to say thank you to Congressman Durbin and his staff, for letting me be a part of this today. Thank you for your time.

Chairman MILLER. Thank you very much for taking your time to be a witness. I know that you are going to school so you may have to leave just a little bit early and we certainly understand that. We really appreciate you taking your time and your effort to be with us this morning.

Dr. Turnock.

**STATEMENT OF DR. BERNARD J. TURNOCK, M.D., DIRECTOR OF PUBLIC HEALTH, STATE OF ILLINOIS**

Dr. TURNOCK. Thank you, Mr. Chairman, and members of the Select Committee. My name is Dr. Bernard Turnock and I am director of the Illinois Department of Public Health, and I greatly appreciate the opportunity to appear this morning on behalf of our Governor, James R. Thompson, to describe Illinois' efforts to deal with our unacceptably high levels of infant mortality.

Governor Thompson would personally like to have participated. He has been very active in this effort, especially in the last few years, and together with a bipartisan majority in the Illinois General Assembly, Illinois has put together in a truly timely manner a variety of programs that have assumed what I believe to be a leadership role in dealing with problems related to infant mortality and teenage pregnancy.

I think this is evidenced by Governor Thompson's appointment to the National Commission to Prevent Infant Mortality; his recent participation as Chairman of the National Governors' Association Task Force on Teen Pregnancy; and by the receipt by our Parents Too Soon teen pregnancy prevention program, of a national award from the Ford Foundation and the Kennedy School of Government under their Innovations in Government Awards Program.

Within the last 2½ years funds totaling over $130 million, including almost $100 million in State General Revenue Funds have been appropriated to deal with teen pregnancy and infant mortality. A program by program, breakdown regarding the programs and the amounts included in those is among the materials that we provided to the committee staff.

I want to emphasize that these massive efforts could not have been undertaken at a more critical point in time in the long history of dealing with infant mortality here in the State of Illinois. From about 1965 through the early 1980s Illinois has made significant progress in closing the gap that has existed between the national rates and the Illinois rates and had virtually closed two-thirds of that gap as of 1985. In 1986 we began to experience what many other states across the country have seen and which in fact is reflected in an analysis of the national figures, and that is a plateauing-off of that reduction.

In 1986, for the first time in more than two decades, the infant mortality rate for the State of Illinois actually increased slightly. It increased from its low in 1985 of 11.6 infant deaths per 1,000 live births to a figure of 12, which was the same as it had been in 1984. Rather than seeing this as an increase or a trend in increasing rates, I think all of us realistically see it as a plateauing-off of the significant progress that has occurred, but it is certainly a signal that we need to redouble our efforts in Illinois.

We have attempted to redouble those efforts beginning in 1986 with the implementation of a program that is entitled "Families With a Future," which is a statewide campaign to reduce infant mortality rates across the State of Illinois but especially in those 27 areas of the State that have the worst pregnancy outcomes.

I will not go into elaborate detail to describe that program. It includes a number of statewide elements that include expanded eligibility for Public Assistance programs, expanded eligibility for WIC programming through the establishment of a State supplemental feeding program that would supplement the Federal funds that we receive. It included expansion of the regionalized perinatal care program through expanded grants to the regional networks. It included additional Parents Too Soon, or teen pregnancy prevention and adolescent parent support service programs that focused heavily on teens and their parents. And it also included very specific targeted efforts in 27 community areas in which community networks would be established to link into the medical care systems and the regional perinatal care systems in ways in which communities themselves would decide what their basic needs were and what basic problems were present that would prevent their proper use of and access to a variety of health services.

The focus of that particular program is on outreach, it is on community education, it is on case management, and it is on supplementing the health support services that are necessary within a community for the health programs such as prenatal care and WIC and regionalized perinatal care to be maximally effective.

As I said, that program began in early 1986, just as our rates were beginning to plateau-out. We believe it represents an approach that will get us back on track.

A second program that, again, I will not describe in great detail because we have provided significant detail in the briefing materials, is our Teen Pregnancy Prevention and Adolescent Parent Support Services Program called Parents Too Soon.

This is a national model, the largest teen pregnancy program that any state has, anywhere in this country. It is one that has been heavily involved in providing services for teen parents as well as providing pregnancy prevention services through community based education, parent-teacher type conferences held across the State, and a variety of other approaches.

Recently that program held what is the first statewide conference anywhere on male responsibility as a key component of our future efforts to deal with teen pregnancy and adolescent parenthood.

Let me skip quickly to the end here.

In addition to Families With a Future and Parents Too Soon, we have also placed additional emphasis on expansion of prenatal care programs during the past 5 years, further development of the State's perinatal network, family planning services, genetic screening, and other related services, all directed toward fighting our unacceptably high infant mortality rates.

Time does not permit me to describe all of these programs here.

The question of access to medical care for low income pregnant women is an important and an emerging issue. I know that the Illinois Public Aid Director Ed Duffy will be testifying specifically on

aspects of that problem when the Committee meets this afternoon in Chicago. I would like to point out, however, that as the payor agency for medical care provided for the indigent in this State, the Department of Public Aid has recognized that access barriers do confront individuals seeking care and are taking steps to remedy this problem. How far that Department can go is dependent at least in part upon budget discussions before the Illinois General Assembly in the next legislative session.

In conclusion I think that while we would agree that we in Illinois have taken many steps in the fight to overcome our high infant mortality rate and to reach the Surgeon General's goal of no more than 9 infant deaths per 1,000 live births by the year 1990, we have much, much more to do. We cannot afford to sit back complacently, and our Governor and our State agencies are committed to continually reviewing and reevaluating the success of current and evolving program efforts, and to take appropriate steps to adjust those efforts as the results would dictate.

Thank you for this opportunity, I will await your questions at the end of this panel.

[Prepared statement of Bernard Turnock, M.D., follows:]

# Testimony
# State of Illinois
# James R. Thompson
# Governor

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## U.S. House Select Committee
## on
## Children, Youth and Families

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## Springfield - Chicago
## October 5, 1987

Presented by:
Bernard J. Turnock, M.D.
Director of Public Health

Table of Contents


| | Page |
|---|---|
| Infant Mortality Reduction in Illinois: An Overview | 1 |
| Appendices | |
| A. Families with a Future | 7 |
| B. Parents Too Soon | 13 |
| C. Prenatal | 21 |
| D. Perinatal Health Care | 23 |
| E. Genetic Diseases | 28 |
| F. Family Planning | 30 |
| Attachment | |
| "Birth Certificate Survey on Access to Prenatal and Well Child Care" | |

# INFANT MORTALITY REDUCTION IN ILLINOIS: AN OVERVIEW

Illinois is proud of the fact that Governor Jim Thompson, joined by a bi-partisan majority of the Illinois General Assembly, has acted in a timely manner, assuming a leadership role nationally, in promoting innovative approaches to address the problem of high infant mortality. These efforts have been recognized at the national level by Governor Thompson's appointment by Congress to the National Commission to Prevent Infant Mortality, his recent participation as chairman of the National Governors' Association Task Force on Teen Pregnancy, and by the award of $100,000 to our "Parents Too Soon" program by the Innovations Awards Program sponsored by the Ford Foundation and Harvard University's John F. Kennedy School of Government.

Funds totaling over $132 million, including some $95.8 million in State general revenue dollars, have been appropriated over the 30-month period beginning January 1, 1986 for the reduction of infant mortality in Illinois. A program-by-program, year-by-year breakdown of this funding is included in Table I. These massive efforts undertaken under Governor Thompson's leadership could not have been implemented at a more critical point in this state's war against infant deaths.

In the Spring of 1985, Governor Thompson asked newly-appointed Public Health Director Dr. Bernard Turnock to prepare a plan for reducing infant mortality in Illinois to meet the U.S. Surgeon General's goal of no more than 9 deaths per 1,000 live births, to be achieved by 1990. In 1985, Illinois' infant mortality rate was 11.6 deaths per 1,000 live births. This rate represented an all-time low for Illinois, following a steady, 20-year decline in our rate of infant deaths. While recognizing that progress had been made, Governor Thompson knew that more needed to be done.

Just as the State's comprehensive, new battle plan was brought on-line, the State's infant mortality rate actually rose 4/10ths of a percent to a level of 12 deaths per 1,000 live births. This alarming reversal, it was soon learned, reflected trends seen recently in other states. The Children's Defense Fund and others have projected that 20 or more states will fail to meet the national goal without innovative and expanded efforts directed toward the reduction of infant mortality. Illinois must accomplish a 25% reduction in its infant death rate to reach the Surgeon General's goal.

Much has been said and written about the relationship of low birth weight to infant death. Regrettably, Illinois has found this link to be a significant contributor to its infant mortality rate. The percent of low birth weight infants in Illinois exceeds the national rate. Recent studies have shown a number of factors to be associated with the incidence of low birth weight. Among these are certain maternal

diseases; prior history of poor reproductive outcomes; pre-pregnancy weight; race; and age. Additionally, social factors such as poverty and one-parent families have been shown to place women at higher risk for low birth weight infants. These same studies have shown that early, consistent and comprehensive prenatal care can reduce the incidence of low birth weight infants in the at-risk population, thereby helping to lower the infant mortality rate.

Examination of data available for the State of Illinois in recent years has demonstrated that the infant mortality rates for births to women receiving inadequate or no prenatal care were more than four times the rate of births to women receiving adequate prenatal care. Similarly, the proportion of babies born at low birth weight to mothers that receive no prenatal care was more than three times that of low birth weight infants born to mothers whose care began in the first trimester of pregnancy.

## FAMILIES WITH A FUTURE

Illinois' newest initiative in addressing its infant mortality problem is the "Families With a Future" program (Appendix A). This model program, which served 22,500 clients in FY 1987, is designed to ensure both quality and continuity of care to individuals and to stimulate both public and private agencies to work cooperatively to reduce infant mortality. At the State government level, six agencies of State government have joined forces to provide the following new programs and services:

1. Medical services are now available for all Public Aid-eligible pregnant women who, for financial reasons, would not otherwise receive prenatal care. (Payments for prenatal care were not previously available for women who were not eligible for "Aid to Families with Dependent Children.")

2. Aid to families with dependent children (AFDC) is provided during the third trimester to pregnant women having no dependent child.

3. Perinatal systems management grants have been expanded.

4. Statewide marketing efforts have been designed to reach the high risk target population.

5. "Parents Too Soon" teen leadership conferences, which have served over 15,000 teens and their parents, are now held throughout the state.

6. Adolescent health promotion programs have been instituted in schools.

7. A new adverse pregnancy outcome reporting system (APORS) has been initiated.

8. Infant day care services have been made available in targeted areas of the state through the Department of Children and Family services.

9. The Illinois State Board of Education has implemented pilot projects in four alternative schools to increase calories and nutrients in the diets of pregnant students.

10. The Women, Infants, and Children Supplemental Food program (WIC) has been expanded to serve over 12,000 new cases in the targeted areas. Some $6 million in state general revenues have been committed to this expansion.

11. Two new projects have been implemented in Chicago by the Department of Alcoholism and Substance Abuse to provide services to substance abusing pregnant women.

The second component of the Families With a Future program is a "targeted network" approach encompassing 27 high risk areas. An extensive array of 19 different medical and social services are available through each local network to carry out each client's care plan. This effort recognizes that meeting needs such as transportation, temporary housing and job training may be as important in improving the outcome of pregnancy as the traditional preventive services such as prenatal care, home follow-up by nurses, and family planning. The 16 networks which have been established to serve the targeted areas include more than 170 local participating agencies.

Finally, a statewide marketing campaign has been implemented, including the development of television public service announcements; graphics for use by local networks in reaching their target population; billboards, bus cards and posters advertising program services, and a statewide referral hotline.

## PARENTS TOO SOON

Another weapon in Illinois arsenal of programs addressing the problem of infant mortality is the Parents Too Soon (PTS) program (Appendix B). Parents Too Soon is the nation's first coordinated statewide assault on the complex problem of teen pregnancy. This program is the recipient of the prestigious "Innovation" award by Harvard University and the Ford Foundation.

This innovative, multi-faceted initiative, begun by Governor Thompson in 1983, is designed to reduce teenage pregnancy and to mitigate its negative consequences: health risks to mothers and infants, high rates of infant mortality, economic dependency, interrupted education, and premature parenting.

Illinois' commitment of over $13.5 million in taxpayers' dollars during fiscal year 1988 makes this the most generously supported state program of its kind in the United States.

Parents Too Soon funds three comprehensive health, social services, and education demonstration projects, as well as 22 family planning programs, 26 prenatal programs, and 27 parent-support programs.

Two major programs within Parents Too Soon are designed to equip teenage mothers on welfare with jobs skills necessary to leave public dependency and establish financial self-sufficiency. This year, through a grant from the Illinois State Board of Education, Parents Too Soon is designing model programs for meeting the special needs of school-age parents.

During the past two years, Illinois has greatly expanded its Parents Too Soon teenage pregnancy prevention activities. Also funded are conferences designed to help teens develop the decision-making skills necessary to take control of their lives, demonstration projects to improve teen's communication with their parents, four locally-controlled, comprehensive, school-based health clinics which provide comprehensive health services to teens (with their parents approval), programs targeted at our highest-risk junior high populations, assistance in developing six community coalitions, and providing technical assistance to local groups wanting to start male responsibility programs. Special attention has been given to the development of these important male-involvement programs; one member of the Department's staff devotes full-time to this effort. Further, the Department has been quite successful in seeking and obtaining the enthusiastic cooperation of local community churches in its prevention programs.

The centerpiece of our prevention programming is our statewide media campaign, "Speaking for Ourselves," in which teens themselves deliver the "bad-news" message of what it means personally to have become a parent too soon. This campaign consists of radio and TV public service announcements, posters and billboards. Another aspect of the media campaign is a song writing contest which attracted over 130 entries by teens. The winning song, entitled "Too Fast", urges teens to stop and think about the future before becoming sexually active.

PTS also operates a highly publicized statewide, toll-free telephone hotline. The hotline received more than 25,000 calls during its first two years of operation. Teens themselves, their parents, or others concerned about young people, call the hotline and are referred to services within their own communities.

In short, we believe that the solution to the teen pregnancy problem requires the mobilization and cooperation of manyy segments of Illinois citizenry: the public and private sectors, health and social service providers, educators, parents and families, churches, politicians and the youth themselves who must learn to take control of their lives.

## PRENATAL HEALTH CARE

The Illinois Department of Public Health has funded prenatal services (Appendix C) in Chicago since 1964 and on a limited basis in the downstate area since 1980. Despite these efforts, there remain about 8,000 women per year delivering infants after receiving little or no prenatal care. Before expanding its efforts in this area, it was critical for the Department to discover the underlying reasons why women were receiving inadequate prenatal care.

Anecdotal reports from the currently funded projects suggested that the reasons for inadequate utilization of prenatal care were varied and would require individualized approaches within communities depending on the problems identified.

Survey results suggest that women know prenatal and well child care are important but need assistance in accessing these services. The Families with a Future Hotline is designed to help families locate the services they need. Those living in the target areas will be linked with case management systems. Directories of MCH services are being disseminated to consumers and providers statewide. MCH materials have been made available for distribution to consumers at local Developmental Disabilities Prevention Fairs in conjunction with Families with a Future activities. These two activities should facilitate consumer knowledge of and access to services statewide.

With this in mind, ten Prenatal Care Projects were begun in Illinois by the Department of Public Health in 1981 with State General Revenue Funds. These grants were expanded to thirty in 1983 as part of the Parents Too Soon Initiative with Title V MCH funding and to 48 agencies in FY88 in conjunction with the Families with a Future program. These projects provide comprehensive prenatal services including: prenatal/postnatal health care with linkages for delivery; social services; nutrition services; health education; outreach and follow-up services.

## PERINATAL HEALTH CARE

Beginning in January, 1975, in compliance with Public Act 78-557 (an Act relating to the prevention of developmental disabilities), the Illinois Department of Public Health established a statewide regionalized perinatal health care system (Appendix D) to provide care to high-risk mothers and newborns. Comprising this system are ten regional perinatal networks. These networks include one or more designated Perinatal Centers.

As a part of the Infant Mortality Reduction Initiative, Families with a Future, the Illinois Department of Public Health has expanded grants for each of the ten regional perinatal networks to help support the development and/or expansion of nondirect patient care services designed to:

a) Place greater emphasis on early identification of high-risk pregnancies through better coordination with providers of preconceptional/perinatal care services;

b) further the development of consultation, referral, communication and transfer mechanisms;

c) support outreach, education and evaluation efforts; and

d) improve coordination of follow-up activities to track high-risk families after discharge.

## GENETIC DISEASES PROGRAM

Newborn screening services have been required in Illinois since 1966 (Appendix E). Initially, testing was performed on all babies for phenylketonuria (PKU). In 1979, Illinois expanded the mandate to include hypothyroidism, in 1984 galactosemia, in 1986 biotinidase deficiency, and in 1987 congenital adrenal hyperplasia was initiated.

In 1983, a statewide network of six centers providing genetic counseling and testing services was established. The goals of this network are to provide diagnostic, counseling, treatment and follow-up services to patients with a genetic disorder and their families, and to educate health care professionals and the public about genetics. Follow-up care and treatment services are provided to children identified through newborn screening in order to maximize their potential for developing normally and to any individual or family in need of these services. This network has expanded each year and presently 10 awards have been granted to continue these services.

In 1986, 78 children were identified, with this number certain to increase as the program expands. Nearly 2000 individuals and families have benefited from support services such as counseling and follow-up care and over 11,000 individuals have been reached through educational activities.

## FAMILY PLANNING

The Family Planning Services program (Appendix F) has been administered by the Illinois Department of Public Health, since July 1, 1983. Funding sources currently include Title V, Title X, Title XX, and state general revenue. Awards are made to 67 public or private not-for-profit entities which provide comprehensive family planning services medical, social, educational and referral services designed to allow clients to voluntarily determine the number and spacing of their children.

During FY86, The Family Planning Services program met approximately 21 percent of the need in Illinois providing services to 151,953 individuals.

## APPENDIX A

### FAMILIES WITH A FUTURE: THE STATEWIDE INFANT MORTALITY REDUCTION INITIATIVE IN ILLINOIS

The Infant Mortality Reduction Initiative, Families with a Future, was conceived to enable Illinois to achieve the national goal set by the Surgeon General of no more than 9 infant deaths per 1,000 live births by 1990. The program is designed to ensure both quality of care and continuity of care to individuals entering service networks and to stimulate both private and public agencies to work cooperatively to reduce infant mortality.

#### The Plan

The program Plan defines a dual approach for reducing infant mortality.

The first is a statewide approach which involves the cooperation of six departments of state government, making available the following new programs and services:

1. Medical services are available for all Public Aid eligible pregnant women who, for financial reasons, would not otherwise receive prenatal care. (Payments for prenatal care had not been available for women who were not eligible for "Aid to Families with Dependent Children.")

2. Aid to families with dependent children (AFDC) is provided during the third trimester to pregnant women having no dependent child.

3. Expanded perinatal systems management grants.

4. Statewide marketing efforts designed to reach the high risk target population.

5. "Parents Too Soon" teen leadership conferences.

6. Adolescent health promotion programs in schools.

7. Adverse pregnancy outcome reporting system (APORS).

The second is a targeted network approach serving the 27 target areas. These target areas are included within the following seven service areas:

1. City of Chicago (19 community areas)

2. South Suburban Cook County (3 target areas)

3. Kankakee County

4. Vermilion County

5. Macon County

6. East Side Health District in St. Clair County

7. Southern Seven Counties of Illinois.

Effective January 1, 1986 the Illinois Department of Public Health funded the health departments in the seven service areas to serve as the lead agencies in planning, systems development and in establishing service networks. Lead agencies are required to establish a community based advisory committee of consumers and providers and to establish networks of providers which offer all services needed for comprehensive care to high risk infants and pregnant women and women at risk of becoming pregnant.

Providers are required to develop working memoranda of understanding with all other providers in the network to assure continuity of care for all individuals served in the network. The cornerstone of the Program is case management and continuity of care for all clients served by a network. The working memoranda of agreement among network providers must detail how, and under what circumstances, referrals will be made and how services will be delivered.

The following services are required:

1. Outreach, case finding, and identification of high risk populations.

2. Comprehensive family planning services for women and men, including adolescents.

3. Preconceptional risk identification and counseling.

4. Free publicized pregnancy testing and counseling.

5. Comprehensive prenatal services with clearly defined linkages for delivery.

6. Well child services, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

7. Nutrition counseling and food supplementation.

8. Health education.

9. At risk and high risk infant and maternal follow-up including home visits.

10. Prenatal home visits.

11. Infant and child day care.

12. Transportation to required services where applicable.

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13. Emergency and non-emergency housing.

14. Birth to age 3 early intervention programs.

15. Substance abuse programs.

16. Psychosocial counseling and family support services.

17. Injury prevention.

18. Environmental protection.

19. Job training and employment services.

Networks are encouraged to enlist the participation locally of the following programs:

- Head Start
- Prenatal
- Parenting
- Parents Too Soon (adolescent health services)
- Family Planning
- Public Aid
- Other Welfare offices
- WIC/Commodity Supplemental Food Program (CSFP)
- SIDS
- Day care providers
- Child and family service providers
- Genetic screening and counseling
- Mental health centers
- Schools
- Substance abuse
- Hospitals including Level III hospitals having letters of agreement with community hospitals
- Community health centers
- Job training and employment

- Birth to age 3 early intervention programs
- Health department(s)
- Housing

It is required that each network application provide assurance that existing programs be an integral part of the network. This approach is designed to avoid duplication of services, and minimize administrative costs.

The importance of the involvement of the regional perinatal networks in planning for network services and their close cooperation with providers of prenatal care, interconceptional care, and home follow-up by public health nurses has been emphasized.

Network Implementation

The Program provided lead agencies a model "Request for Proposals" to be used in attracting network providers. Each lead agency conducted bidders conferences to describe the Program including network responsibilities. Deadlines were established for submission of applications.

In Chicago because of the large number of target areas (19) the formation of community networks was facilitated at a bidder's conference and technical assistance meetings by breakout sessions which grouped community areas into "suggested" networks.

Six of the ten Chicago networks consist of a single community area. Four networks are comprised of two or more community areas.

Each network has identified a Community Network Coordinating Entity (CNCE) which receives and allocates funding for network services.

By June 30, 1986 the five downstate networks, one network in south suburban Cook County, and all 10 Chicago networks had been funded.

Allocation of Funds

A formula for allocation of network funds is required by the Infant Mortality Reduction Act. The formula considers, for each of the targeted areas, three years of data (1982 through 1984) on the following eleven factors related to high infant mortality:

1. number of infant deaths
2. number of live births
3. infant mortality rate
4. teen pregnancy rate
5. fertility rate
6. illegitimacy rate
7. inadequate prenatal care rate
8. low birth weight rate
9. excess death rate
10. per capita income
11. number of women 15-44

Reporting and Evaluation

The evaluation plan for the Families with a Future Program will address implementation, impact, and outcome. During the first year, evaluation centered on the nature and extent of implementation. The first year's evaluation process consisted of comparing the list of required services with structured abstracts of each network's activities and site visit findings.

In FY88, the Illinois Department of Public Health will begin to evaluate the impact of the Families with a Future Program. Networks were involved during the first year of the Program in establishing process objectives for FY88 which serve as the basis of a uniform statewide performance assessment tool.

Network providers prepared process objectives for their individual projects in light of the initiatives' outcome objectives. Representatives of the networks rated each objective for importance in achieving the objective of 9 infant deaths per 1,000 live births by 1990. Importance scores were weighted by the panelist's subjective rating of their own confidence in their opinion as a means of compensating for varying expertise in MCH issues. The process was expedited by the use of a personal computer on site; three Delphi rounds were completed in one and one-half days. Selected objectives are being used by the networks to direct program activities as well as by IDPH program administrators to identify the reporting criteria currently used to assess network performance.

Existing reporting systems have been used to minimize additional reporting. Each network has purchased a personal computer system. This system will be used to gather and store client and case management data. Client data reported by networks will be used to evaluate the FY88 performance of individual networks as well as the entire Program.

Illinois is currently implementing a statewide "Public Health Information Network," providing a microcomputer to each local health department to ensure rapid communication between and among local health departments and the Central Office. This system will be used to facilitate transmission, reporting and analysis of FWF data at the state level.

Lead Agency and Network Development

During the past year lead agencies and networks have evaluated their personnel needs and have made several changes. The Chicago Department of Health has doubled its staff. Other lead agencies and many networks have changed the nature of their staffs, moving from a development mode into an operations posture.

Service areas have been expanded in two areas. The Chicago Department of Health, utilizing Community Development Block Grant funds added three community areas to the original 19 city target community areas. The Cook County Department of Health added two communities to its FWF service area.

Several Chicago networks, after initially targeting services to teens, have found that women over 20 years of age in their area were the major contributors to infant mortality. These networks have, during the past year, changed the focus of their program from teens to the over 20 year old woman.

Looking to the Future

We are now entering the second full year of funding of the Program. FY88 funding allocations are based upon updated information (1983, 1984, and 1985). As we enter the second year, we are continuing to rely on the leadership of the seven lead agencies originally charged with administration of 16 networks of services. These networks encompass and fund the service of 170 provider agencies.

The responsibility for development of the 10 community networks in Chicago during FY87 was carried jointly by the IDPH with the Chicago Department of Health because of the number of affected areas and need to organize local agencies and generate community support. A significant change for FY88 will be the full assumption of Lead Agency responsibilities by the Chicago Department of Health.

FY88 priorities include:

1. Establish a data reporting system for program evaluation.

2. Redirection of marketing activities focusing on local programs.

3. Provision of technical assistance on the following subjects:

   a. Case management
   b. Linkage agreements
   c. Needs assessments (prioritize allocation of funds locally)
   d. Data system

4. Staffing the perinatal steering committees.

5. Appointment of the Infant Mortality Advisory Board.

6. Interagency coordination.

7. Participation in the drug abuse in pregnancy seminar (September, 1987).

8. Develop linkages with the Department of Commerce and Community Affairs which will result in expanded employment opportunities in targeted areas.

A long range objective of this program is to demonstrate the applicability of the Families with a Future model in reducing infant mortality.

APPENDIX B

PARENTS TOO SOON

Problem and Approach

Parents Too Soon is the nation's first coordinated statewide assault on the complex problem of children having children.

This innovative, multi-faceted initiative, mandated in 1983 by Illinois Governor James R. Thompson, is designed to reduce teenage pregnancy and to mitigate its negative consequences: health risks to mothers and infants, high rates of infant mortality, economic dependency, interrupted education, and premature parenting.

Parents Too Soon is a national model, and Illinois' commitment of $12 million in taxpayers' dollars during fiscal year 1987 makes this the most generously supported state program of its kind in the United States.

Parents Too Soon coordinates and sponsors more than 125 community-based projects. A key to the program's success is the principle of real partnership with local citizens, who design programs to meet the unique needs of their own communities. Initiative-funded programs can be found in county public health centers, hospitals, public schools, church-affiliated service centers, and in social service and mental health agencies.

The initiative addresses the needs of both males and females between the ages of 10 and 20. Participants may be teen parents, pregnant girls, or teens at risk of too-early parenthood. In the past fiscal year, more than 31,000 teens were reached with direct services.

At first, Parents Too Soon provided mostly medical and social services to pregnant and parenting teens. In the past year, the initiative has concentrated on primary prevention.

And we're seeing a difference. We can see already a marked improvement in the health and outlook of our initiative's teen-parent families. We are seeing fewer repeat pregnancies. Birth weights of program participants' babies are higher than their community averages. More are completing their educations and training programs. More are finding work and ending welfare dependency. Their infants are healthier, more verbal, and more curious than the children of non-participants in similar environments.

Our prevention programs are succeeding too. We have seen an 18-percent decrease in births to Illinois teens aged 15-to-19, over the past five years.

The problem is bigger than teenagers, but so is the program. Last year, in addition to more than 117,000 teens, thousands of their parents, teachers and other citizens participated in Parents Too Soon education programs -- in the inner cities, in the suburbs, in rural towns. Expanded primary prevention efforts brought to television viewers, radio listeners, and public transit riders a media campaign of real teens speaking frankly about the harsh realities of having become "parents too soon". Locally controlled and community-approved school-based clinics have been started in East St. Louis, Kankakee and two in Chicago. And we have also developed teenage male-involvement programs.

The solution to the problem has required the mobilization and cooperation of every segment of society in Illinois: the public and private sectors, health and social service providers, educators, parents and families, churches, politicians, and the youth themselves, who must learn to take control of their lives.

The Parents Too Soon initiative has brought the problems of teenage pregnancy and parenting to the attention of our people, and has challenged them to commit their efforts, their creativity, and their taxes to solving those problems. The people of the State of Illinois are responding. It works.

A unique interagency collaboration has been established to oversee this initiative, which was conceived in Governor Thompson's office. Three state agencies -- the Departments of Public Health, Public Aid and Children and Family Services have forged an extraordinary working relationship.

Instead of a single lead agency, each of the three departments assumes a portion of the program's responsibilities. All three agencies share in its management. Parents Too Soon has a single, unified budget, which is developed and presented to the General Assembly jointly by all three department directors.

Program staff is allocated among the departments, under a single overall program coordinator. Program staff meet quarterly with the three directors, who rotate the chairmanship of this management group.

This joint-oversight approach extends to the community level. Collaboration among local agencies is required. In order to receive Parents Too Soon funding, local agencies must provide letters of agreement with related youth-serving agencies in their communities. They must agree to formally refer participants among themselves, and they are strongly encouraged to collaboratively plan activities.

Goals

To help provide realistic hopes for a better future for parents and infants who are both children, the Illinois Parents Too Soon initiative has adopted three major goals that are intended to be met through prevention and treatment services.

1) Reduce the incidence of teenage pregnancy;
2) Reduce the health risks associated with adolescent pregnancy, especially the rate of infant mortality; and
3) Improve the teen parents' ability to cope with the responsibilities of parenthood.

Target Population

Parents Too Soon services are directed toward males and females, ages 10-to-20.

Illinois' average teen mother is 15.5 years old. Some 150,000 infants and pre-schoolers live with their teen moms, two-thirds of whom are high school dropouts, two-thirds of whom are unmarried. (Half of all women currently receiving AFDC in Illinois were born to unwed teen mothers).

The program operates a highly publicized statewide, toll-free telephone hotline. The hotline received more than 25,000 calls during its first two years of operation. Teens themselves, their parents, or others concerned about young people call the hotline and are referred to services within their own communities.

Local programs make Parents Too Soon services available in about 75 percent of Illinois' 102 counties and in all its areas of high population density. Service sites were selected after extensive demographic analysis and are concentrated in communities with high rates of teen pregnancy, infant mortality, and unemployment.

Funded community service programs also conduct their own locally designed outreach programs. In the last fiscal year, approximately 24 percent of all adolescents who gave birth in Illinois received their prenatal care through Parents Too Soon programs. The 117,000 young people who received educational services that same year through Parents Too Soon represent about 13 percent of Illinois' total adolescent population.

Principal Activities

Parents Too Soon has organized and mobilized a wide variety of both treatment and prevention programs through collaborative efforts of the health, social services and educational/vocational sectors at both the state and local levels.

Three comprehensive demonstration projects provide health, social, and educational services. We fund 22 family-planning programs, 26 prenatal programs, and 27 parent-support programs.

Two major programs are designed to equip teenage mothers on welfare with the jobs skills necessary to leave public dependency and to establish financial self-sufficiency. This year, through a grant from the Illinois State Board of Education, Parents Too Soon is designing model programs for meeting the special needs of school-age parents.

During the past two years, the initiative has expanded teenage pregnancy prevention activities. Among these programs are four school-based clinics, which are locally controlled and which provide services to teens with their parents' approval. We have put on 37 locally run conferences, designed to help teens develop the decision-making skills necessary to take control of their lives. We have conducted 9 demonstration projects to improve teens' communication with their parents, 17 programs targeted at our highest-risk junior high populations, and helped create six community coalitions. One staff member works exclusively in providing technical assistance to local groups wanting to start male responsibility programs. Further, the Department has been quite successful in seeking and obtaining the enthusiastic cooperation of local community churches in its prevention programs.

The centerpiece of our prevention programming is our statewide media campaign -- "Speaking for Ourselves" -- in which teens themselves deliver the "bad-news" message of what it means personally to have become a parent too soon. This campaign consists of radio and TV public service announcements, posters and billboards. The other aspect of the media campaign is a song-writing contest which solicited over 130 entries by teens. The winning song entitled "Too Fast" urges teens to stop and think about the future.

Role and Reporting Relationships of Participating Agencies

Strong leadership and personal involvement by Governor James R. Thompson -- in whose office the idea of the Parents Too Soon initiative was developed -- has led to an effective and unique interagency cooperative organization (as described in section 2 above). Policy is set and directed by an interagency "triumvirate" of the directors of the Departments of Public Health, Public Aid, and Children and Family Services.

Every two months, there are program staff meetings among all the state agencies involved in the initiative, which, in addition to the three departments mentioned above, include: the Illinois Departments of Commerce and Community Affairs, Alcoholism and Substance Abuse, Mental Health and Developmental Disabilities, Employment Security, the State Board of Education, the Governor's Planning Council on Developmental Disabilities, and the Division of Services for Crippled Children.

An interesting aspect of the Parents Too Soon organization is its public-private partnership with the Ounce of Prevention Fund. All of the services funded through the Department of Children and Family Services are administered by the Ounce of Prevention Fund. The "Ounce" was begun in 1982 by Irving Harris of the Pittway Corporation Charitable Foundation and the Department of Children and Family Services to promote healthy family functioning. With the advent of Parents Too Soon, they were the obvious linkage to parenting programming and to cooperation with the private sector. The partnership with the "Ounce" has evolved into further collaboration with private foundations in the funding of our school-based clinics.

Funding

The Parents Too Soon FY'88 budget is $13.5 million. Funding is from a combination of Federal block grants and State General Revenue dollars. Additionally, there are private foundation funds and significant private donations that are not reflected in the $13.5 million appropriated by the General Assembly.

From year to year this funding formula has changed. One of the advantages to the interagency collaboration is that the funding mix can be more flexible. For instance, in a year when MCH dollars were meager, a greater portion of the budget was funded through the SSBG. As the SSBG available dollars dwindle each year, more State dollars are being put into the formula. In FY88 Parents Too Soon will request nearly $7 million in State General Revenue funds.

Private foundation funding comes through the Ounce of Prevention Fund. Nearly $500,000 of Pittway Corporation Charitable Foundation and Harris Foundation funds help to run the operation of the "Ounce". In addition, $300,000 has been raised by the "Ounce" to help finance two of the school-based clinics in Chicago.

This year for the first time, Parents Too Soon has realized significant in-kind donations. The media campaign "Speaking for Ourselves" has received over $100,000 in donated billboard space statewide, not to mention the public service air time broadcasters have donated. At Christmas time over $30,000 in toys were donated to the children of participants in the welfare-to-work program.

Program Development and Implementation

Illinois' teen pregnancy initiative emerged incrementally, until it coalesced into the Parents Too Soon program that was launched from Governor Thompson's office in 1983. The program has subsequently served as the organizational model for Illinois' Infant Mortality Reduction Initiative.

In 1980, the Coalition of Women Legislators held hearings around the State on adolescent pregnancy and subsequently passed legislation calling for a Task Force on Adolescent Parent Support Services. The Task Force, composed of public and private members, issued a report in 1982 calling forth 40 recommendations for comprehensive programming. The plan became the basis for Parents Too Soon.

In 1982, the Ounce of Prevention Fund was formed as a public/private partnership between the Department of Children and Family Services and Irving Harris of the Pittway Corporation Charitable Foundation. Their charge was to prevent child abuse and neglect and promote healthy family functioning. Most of their early program participants were teenage mothers.

Also in 1982, the Department of Public Aid and the Children's Policy Research Group at the University of Chicago released a study of 2,000 teen welfare mothers that indicated the need for a program of support.

In 1983 the Governor's Task Force on Children and the Governor's Human Services Sub-Cabinet recommended a program such as Parents Too Soon. When in April Federal Jobs Bill funds became available, the decision was made by Governor Thompson to use a portion of these new dollars to launch a coordinated, statewide teen pregnancy initiative called Parents Too Soon.

Milestones in Program or Policy Development and Implementation

1982 -- The Report of the Task Force on Adolescent Support Services was issued. This report provided the basic plan for Parents Too Soon.

1982 -- The Ounce of Prevention Fund was begun. This public/private partnership would become a key contractor for Parents Too Soon.

1983 -- Emergency Jobs Bill funding was authorized by Congress. This sudden influx of dollars into states enabled Illinois to fund the plan issued the previous year by the Task Force.

1983 -- Parents Too Soon was launched by Governor James R. Thompson.

1984 -- All programs were fully operational.

1985 -- Decision was made by "Triumvirate" that all program expansion would henceforth be in the area of primary prevention.

1986 -- For the first time State General Revenue dollars were appropriated to Parents Too Soon.

1987 -- Governor Thompson chairs the National Governor's Association Task Force on Teen Pregnancy in recognition of Illinois' leadership in this area.

Individuals and Organizations Involved in Program Development, Implementation and Operation

The Department of Children and Family Services (DCFS) selected the Ounce of Prevention Fund to administer its portion of the Parents Too Soon initiative. The "Ounce", a public/private partnership between DCFS and the Pittway Corporation Charitable Foundation, was established in 1982 to help prevent the cummulative family problems that can result in child abuse and neglect, infant mortality, delayed development in children, and repeated cycles of teenage pregnancy and parenthood. The "Ounce" develops, monitors, and evaluates projects designed to address these problems, conducts research to aid in identifying causes and potential solutions, and provides training and technical assistance to enable community organizations such as churches, social services agencies, health clinics, and other organizations to carry out prevention programs.

In 1984, the Ounce of Prevention Fund's 28 programs offered social, recreational, educational, parent/child, health-related, and employment related services designed specifically for pregnant and parenting adolescents.

In FY86, thirteen new primary prevention programs were added to the list of sites which were currently providing on-going services for pregnant and parenting teens. This expansion was implemented to enhance communication between parents and teens on issues of sexuality and decision making and to provide activities for teens that are positive alternatives to early parenthood.

In FY86 also, Parents Too Soon received a grant from the State Board of Education under the Carl Perkins Vocational Act, to develop model programs to demonstrate effective methods of reaching, educating and training single teenage parents for employment.

Supporters and Critics of the Program

The Parents Too Soon initiative had operated from the outset under the strong leadership and personal involvement of Governor Thompson, a Republican. And, from the outset, the initiative has received the strong and consistent backing of the General Assembly, controlled by Democrats. It's unanimous. We are united in our desire to reduce teen pregnancy and its negative impacts.

However, with the start-up of school-based clinics during the past year, there has been some pointed opposition from conservative religious and civic

organizations. This opposition insists that there can be but a single thrust in teen pregnancy prevention -- that abstinence is the only moral approach to prevention.

Governor Thompson has stated that abstinence, self-control and sound decision-making must be taught our youth, but that in our pluralistic society the use of contraceptives does not always present a moral issue. He also points out that access to these locally developed and controlled school-based clinics is limited to youths who have received prior written consent from their parents.

Obstacles

Building cooperative working relationships at the local level is the most significant obstacle encountered in the program. "Turfism" will not be overcome overnight, nor in the space of a few short years. In many areas of the State, progress has been made in collaboration between youth serving agencies, but much work yet remains.

Because the needs of teen parents and youth at risk of early parenthood are many, agencies must work cooperatively to ensure a continuum of services for these young people. That continuum has traditionally been absent due both to issues of turf and structural obstacles handed down from State and Federal funders. The Parents Too Soon initiative has taken steps to overcome both issues of turf and structure.

All local contracting agencies are required to provide letters of agreement with other youth serving agencies in their community before they will be funded. A statewide referral form is in use with all funded agencies that allows for better tracking and follow-up. With an increase in the prevention focus of the initiative, the State funders have encouraged local agencies to draw up plans for coordinated delivery of community education programs. In a growing number of areas, we have required a coordinated application as a requirement for funding of prevention dollars.

We have also taken steps to overcome the obstacles raised by State policies. For instance, at the outset of the initiative the Department of Public Aid identified a Parents Too Soon liaison in each of their offices so that a teenager seeking the services of the welfare department could cut through the red tape which sometimes occurs in the process of applying for welfare. Thus, she could gain access to medical benefits sooner.

Measures for Evaluating Program Success

Three demonstration projects in the state offer comprehensive services to teens. Success is evaluated by measuring : 1) low birth weight, 2) infant mortality, 3) repeat pregnancies.

LOW BIRTH WEIGHT: During 1985, 8.3% of the infants born at Mile Square Health Project were low birth weight as compared to the community rate of 14.3% (for teens). During 1986, the project had a 9% low birth weight percentage. The project at Winnebago County Health Department demonstrated a 7% low birth weight percentage as compared to 8.8% for

births to teens in the county. During 1986, this project's low birth weight percentage was 7.56%. For the project at the Southern Seven Health Department during 1985, 13.3% of the infants born were low birth weight compared to 13.6% for the seven county area. During 1986, they demonstrated an impressive 8.8% low birth weight percentage. (State statistics are unavailable for 1986 at this time.)

INFANT MORTALITY: The reduction in the incidence of infant mortality among program participants was equally impressive. During 1985 at Mile Square there was one infant death in the 312 births to teens. For the over-all community from which Mile Square participants come there were 26 infant deaths among the 1058 teen births not receiving care at Mile Square. In Winnebago County there were 2 infant deaths from the 399 teen births treated at the project compared with 5 among the 103 not utilizing the program. Southern Seven had no infant deaths among its 120 teen births while there were 3 among the 57 births not utilizing the program. During 1986, the project at Mile Square had 2 infant deaths (twins), the project at Winnebago had 1 infant death and the project at Southern Seven Health Department had 0. (State statistics are unavailable for 1986 at this time.)

REPEAT PREGNANCIES: Throughout Illinois, about one out of every three teen births is a repeat birth. At Mile Square less than 7% of the participants had a repeat birth from July 1984 to March 1986. At the Southern Seven project, the repeat births have been a remarkable 2% in 1985 and 1986.

Replication of the Parents Too Soon Model

The interagency model described in above has already been used by other states. In 1985 Illinois acted as advisor to a teen pregnancy program development process initiated by the Council of State Planning Agencies. Other states participating included New Mexico, Pennsylvania, Colorado, Florida and New Hampshire.

Individual program components already shared with other states include our Hotline which has been used as a model by Pennsylvania and Colorado; our 1986 media campaign which has already been taken up by Alabama and New Hampshire with many states still contemplating replication. The state of Michigan has expressed interest in modeling a program after our welfare component and we have received a Federal demonstration grant to replicate it in Illinois. The state of Maryland is replicating the family support model used by the Ounce of Prevention Fund in their programs. Our Teen Conferences provide a model that we have replicated many times over within Illinois.

Governor Thompson has expressed Illinois' willingness to share Parents Too Soon successes with other state agencies by assuming leadership of the National Governor's Association Task Force on Teen Pregnancy. We are proud of Illinois' progress in finding solutions to the teenage pregnancy problem.

APPENDIX C

PRENATAL CARE PROJECTS

It is well established and accepted that prenatal care can favorably effect infant survival and health. Even controlling for all other factors, adequate prenatal care greatly reduces infant mortality and morbidity as well as the economic, social and personal costs incurred. Prenatal care has been shown to lower the incidence of low birth weight babies, a condition associated with cerebral palsy, mental retardation, learning disabilities and other developmentally disabling conditions. Another factor that greatly influences the quality of life is fetal stress which is associated with the birth experience. It has been demonstrated that infants experiencing such stress have a higher incidence of placement in special education classes and lower IQs. It is further recognized that some stress factors such as toxemia can be significantly reduced through prenatal care. Examination of data available for the State of Illinois in recent years demonstrated that the infant mortality rates for births to women receiving inadequate or no prenatal care were more than 4 times the rate of births to women receiving adequate prenatal care. The proportion of babies born at low birth weight to mothers receiving no prenatal care was more than 3 times the proportion of low birth weight infants born to mothers receiving care in the first trimester of pregnancy.

With this in mind, ten Prenatal Care Projects were begun in Illinois by the Department of Public Health in 1981 with State General Revenue funds. These projects provide comprehensive prenatal services including: prenatal/postnatal health care with linkages for delivery; social services; nutrition services; health education; outreach; follow-up services. Services are being provided through a variety of mechanisms including: comprehensive services at a single site; subcontracts with hospital-based clinics, private physicians or county medical societies for medical services with screening and support services provided by the grantee. All physician services, lab services and drugs are provided at the prevailing Public Aid rates for those pregnant women who are medically indigent but not Public Aid eligible. Those totally or partially funded under General Revenue have no age restrictions. For those projects funded under the Title V MCH Block Grant as part of the Parents Too Soon Initiative, services initially were restricted to women 20 years of age or under.

During fiscal year 1986, 30 agencies were funded. Title V - Parents Too Soon funded projects were opened up to women over 20 years of age with the understanding that priority was still to be given to adolescents. This step was taken by the Department based upon documentation of the number of adolescents becoming public aid eligible, far in excess of what was anticipated, and the increased need for subsidize prenatal care being identified for women over 20 years of age. Payment for medical services continued to be restricted to those women who were medically indigent but non-public aid eligible with reimbursement rates to providers continuing to be restricted to Public Aid rates.

Final statistics demonstrate that the projects were well targeted. The slight decrease in the percent adolescent and unmarried women from FY85 were due to the elimination of the age restriction for the Title V funded projects. There was an associated increase in the number of married women in their twenties being covered. Overall, these was an increase in the total number of women receiving subsidized medical care with the projected caseloads being exceeded for both the nonmedical and medical care services. Expenditures were well distributed with 10% going to administration, 46% to support services, and 45% to medical care. Of the $1,537,364 ($525,000 General Revenue, $1,012,364 Title V), $1,306,211.60 or 85% was expended. Pregnancy outcomes were excellent with an 8% low birth weight rate, representing a decrease from the preceding fiscal year. A total of 6,416 women were served, of whom 3,087 received subsidized medical care.

Data for FY87 are not yet available.

The Prenatal Program was expanded to 48 agencies in FY88 under Title V MCH funds expanding coverage to 73 of the 102 counties in the state. This latest expansion is being done in conjunction with the Infant Mortality Reduction Initiative (Families with a Future) begun in FY86.

APPENDIX D

ILLINOIS PERINATAL HEALTH CARE PROGRAM

Goals and Objectives

Broad goals for state and regional perinatal programs include (1) the reduction of maternal, fetal and neonatal mortality and morbidity to the lowest attainable levels; and (2) efficient utilization of available resources, balanced with patient needs. Health care needs and morbidity rates should be broadly interpreted to include psychosocial as well as physical or organic problems. The concept of an irreducible minimum in mortality or morbidity rates is unacceptable as a limit to improvement in perinatal medicine or health care.

Overview

Beginning in January, 1975, in compliance with Public Act 78-557 (an Act relating to the prevention of developmental disabilities), the Illinois Department of Public Health established a statewide regionalized perinatal health care system to provide care to high-risk mothers and newborns. Comprising this system are ten regional perinatal networks. These networks include one or more designated Perinatal Centers. A Perinatal Center is a referral facility capable of providing the highest level of obstetric and newborn care appropriate to the high-risk patient before, during, and after labor and delivery. It is characterized by the availability of specialized personnel, equipment, laboratory, transportation, consultation, and other support services and resources. To date, there are 19 designated Perinatal Centers. They are located in St. Louis (which serves residents of Southern Illinois), Springfield, Peoria, Rockford, and the Chicago metropolitan area. (Refer to attachment # 1 for a complete listing of Perinatal Centers and hospitals by regional perinatal network.)

Essential components of the Illinois Perinatal Health Care Program include:

1. Transportation. Specific plans are developed by the Perinatal Centers for transportation of high-risk patients requiring intensive care. Teams of doctors, nurses, and respiratory therapists are available from the Perinatal Centers to transport mothers and babies to the Perinatal Center from the local community hospital in special ambulances or helicopters. The Perinatal Center may utilize the Division of Emergency Medical Services and Highway Safety of the Illinois Department of Public Health to arrange for transportation services. Mothers known to be at risk may be transported before their baby is born to deliver in the Perinatal Center. Infants born prematurely, or with other special problems, may be transferred shortly after birth.

2. Consultation. Each Perinatal Center has doctors and nurses available who can provide consultation to local community medical personnel caring for high-risk mothers and babies. This would include consultation in cases of maternity and neonatal complications, as well as neonates with handicapping conditions, and recommendations for transfer to the Perinatal Center.

3. Education and Outreach. Each Perinatal Center is required to implement a plan for continuing education of health care personnel providing perinatal care in local community hospitals. This education may consist of short formal courses or workshops on a variety of obstetric and newborn topics. It may also include visits to individual community hospitals to offer in-service education and consultation for procedures and policies of perinatal care as delivered in the community hospital. Joint perinatal mortality and morbidity review is a further example of outreach education services provided to community hospitals.

4. Follow-up. Community health nursing follow-up is an important part of the Illinois Perinatal Health Care Program. The local public health department, visiting nurse association or home health agency in the family's county of residence will visit the home to provide information, guidance, counseling and physical assessment to high-risk infants at periodic intervals and to certain high risk mothers. These visits are offered as a service of the Illinois Perinatal Health Care Program and the local health agency. These services are available to Illinois residents in all 102 counties and involve 107 local community health agencies. They are made at no cost to the family by utilizing resources from Basic Health Services grants to local public health departments and the federal Maternal and Child Health Block Grant.

5. Data Collection. Each Perinatal Center is required to report to the Illinois Department of Public Health on the patients it serves. This is done to provide statewide data on high-risk pregnancies for use in assessing trends in selected pregnancy outcomes, in monitoring the activity of the Perinatal Centers, and in program planning.

More recent program developments include:

1. Perinatal Facility Designation

Since August, 1984 all hospitals licensed under the Illinois Hospital Licensing Act and providing maternity and newborn care have been required to comply with Illinois Department of Public Health standards for perinatal care. These standards, which are developed in conjunction with the Department's Perinatal Advisory Committee (PAC) and administered by the Division of Family Health, Perinatal Health Care Program, include an executed Letter of Agreement with a designated Level III Perinatal Center. The Letter of Agreement between a Level I or Level II perinatal facility and its Perinatal Center is a major requirement for perinatal facility designation by the Illinois Department of Public Health.

2. Perinatal Services Block Grant

There is a well acknowledged need to expand the focus of the regional perinatal networks through:

a) Greater emphasis on early identification of high-risk pregnancies through better coordination with providers of preconceptional/perinatal care services;

b) Further development of consultation, referral, communication and transfer mechanisms;

c) Support of outreach, education and evaluation efforts; and

d) Improved coordination of follow-up activities to track high risk families after discharge.

In response to this goal, the Illinois Department of Public Health has provided grants to each of the ten regional perinatal networks through its Perinatal Services Block Grant Program to help support the development and expansion of these nondirect patient care services. Resources available in fiscal year 1988 to support these system activities include $2,418,300 of federal MCH Block Grant monies and $1,125,500 of State General Revenue funds for a total of $3,543,800.

These components of a regional perinatal program are largely underdeveloped as compared with direct patient care activities. The development of these components can serve to maximize the impact of preconceptional/prenatal and infant follow-up approaches to improving pregnancy outcome. Such support can serve as an investment that would actually lessen the need for future outlays of resources for specialized maternal and newborn treatment services.

In order to assure local community representation and participation in the planning and development of each regional perinatal program, the Illinois Department of Public Health has required the establishment of regional "management groups" as a condition of award for Perinatal Services Block Grant funds. In addition, each regional perinatal network is required to develop a Plan for Perinatal Care which will outline the local needs of the perinatal region, propose programs and services to address these needs, and determine the resources needed to implement objectives.

3. Perinatal Advisory Committee

A vital element of the Illinois Perinatal Health Care Program is the Perinatal Advisory Committee or PAC. The

Committee is comprised of 22 professional and lay (consumer) representatives of the different settings in which perinatal care is provided. The Committee is established to advise the Illinois Department of Public Health on health policies and issues affecting the provision of perinatal health care and implementation of the State's Perinatal Plan.

In summary, regionalized perinatal care is not a panacea, but it is a strategy that holds much promise. Unless joined closely with the social and medical support system throughout its region, its benefits will be limited. Regional perinatal care offers the best opportunity to begin to structure an organization of maternal and infant care that will begin to deal with the complex interplay of social, medical and environmental factors that determine the outcome of pregnancy and early life.

STATE OF ILLINOIS
REGIONAL PERINATAL
CENTERS
JO DAVIESS
STEPHENSON
WINNEBAGO
BOONE
MC HENRY
LAKE
CARROLL
OGLE
DE KALB
KANE
COOK
DU PAGE
WHITESIDE
LEE
KENDALL
WILL
HENRY
BUREAU
LA SALLE
GRUNDY
ROCK ISLAND
MERCER
KNOX
STARK
PUTNAM
MARSHALL
LIVINGSTON
KANKAKEE
WARREN
HENDERSON
PEORIA
WOODFORD
IROQUOIS
FULTON
HANCOCK
MC DONOUGH
MC LEAN
FORD
TAZEWELL
MASON
VERMILION
CHAMPAIGN
CHUYLER
LOGAN
DE WITT
PIATT
ADAMS
BROWN
CASS
MENARD
MACON
PIKE
MORGAN
SANGAMON
DOUGLAS
EDGAR
SCOTT
SHELBY
MOULTRIE
COLES
GREENE
MACOUPIN
CHRISTIAN
CLARK
CALHOUN
MONTGOMERY
CUMBERLAND
JERSEY
FAYETTE
EFFINGHAM
JASPER
CRAWFORD
MADISON
BOND
CLAY
MARION
RICHLAND
LAWRENCE
CLINTON
ST CLAIR
WAYNE
WABASH
MONROE
WASHINGTON
JEFFERSON
EDWARDS
RANDOLPH
PERRY
HAMILTON
WHITE
FRANKLIN
JACKSON
WILLIAMSON
SALINE
GALLATIN
UNION
JOHNSON
POPE
HARDIN
ALEX
PULASKI
MASSAC
REGIONAL NETWORK
DESIGNATED LEVEL III
PERINATAL CENTER

## APPENDIX E

## GENETIC DISEASES PROGRAM

### Purpose

The goal of the Genetic Diseases Program of the Illinois Department of Public Health is to prevent mental retardation and developmental disabilities by screening all newborns in the state for certain metabolic disorders, and ensuring statewide comprehensive genetic counseling and follow-up care to all individuals in need.

### Background

Newborn screening services have been required in Illinois since 1966. Initially, testing was performed on all babies for phenylketonuria (PKU). In 1979, Illinois expanded the mandate to include hypothyroidism, in 1984 galactosemia, in 1986 biotinidase deficiency, and in 1987 congenital adrenal hyperplasia was initiated.

Infants with these conditions who are not detected and treated will most certainly suffer from severe consequences of the disorder ranging from mental retardation and developmental disabilities to death. These particular disorders are ideal targets for newborn screening since tests are reliable and cost-effective, and early treatment can prevent the serious consequences of these diseases.

During 1983, a statewide network of six centers providing genetic counseling and testing services was established. The goals of this network were to provide diagnostic, counseling, treatment and follow-up services to patients with a genetic disorder and their families, and to educate health care professionals and the public about genetics. Follow-up care and treatment services were provided to children identified through newborn screening, in order to maximize their potential for developing normally, and to any individual or family in need of these services. This network has expanded each year and presently 10 awards have been granted to continue these services. Centers receiving funds are:

1. University of Illinois at Chicago
2. Lutheran General Hospital/Parkside Human Services Corporation
3. Southern Illinois University School of Medicine
4. University of Illinois at Urbana
5. Illinois Masonic Medical Center
6. Rush Presbyterian-St. Luke's Medical Center
7. University of Illinois Comprehensive Sickle Cell Center
8. Washington University Medical School (for services in Carbondale, Illinois)
9. Loyola University Medical Center

Accomplishments

During the 20 years since newborn screening has been mandated in this State, 800 newborns have been detected and spared from the devastating consequences of an untreated disorder that would have resulted in health impairment, institutionalization or death.

In 1986, 78 children were identified, with this number certain to increase as the program expands.

Close to 2000 individuals and families have benefited from support services, such as counseling and follow-up care, and over 11,000 individuals have been reached through educational activities.

Future Activities

With the development of new technology and testing procedures that will allow for early detection, treatment and prevention of developmental disabilities, expansion of services offered through this program will continue. It is anticipated that screening for other serious disorders including sickle cell disease may be implemented in the near future.

There will always be a continuing need for the support of this program which is a vital means for prevention of developmental disabilities in the State of Illinois.

## APPENDIX F

### FAMILY PLANNING SERVICES PROGRAM

The Family Planning Services Program has been administered by the Illinois Department of Public Health, the designated public health agency of the state, since July 1, 1983. The funding sources currently include Title V, Title X, Title XX, and general revenue. Awards are made through an application process to public or private not-for-profit entities which provide comprehensive family planning services medical, social, educational and referral services designed to allow individuals to voluntarily determine the number and spacing of their children.

During FY86, the Illinois Department of Public Health's Family Planning Services Program met approximately 21 percent of the need in Illinois through 57 agencies providing services to 151,953 individuals. These agencies included eight hospitals, 29 local health departments, eight single service family planning centers and 12 multi-service organizations.

The program plan for 1988 is to maintain and expand the provision of family planning services by contracting with providers throughout the state. Chlamydia screening will be added to the services provided in February 1988. Community education activities will be expanded and the program reimbursement system will be monitored and evaluated. In addition to ongoing monitoring and evaluation activities, staff will perform client visit record audits to assess appropriate utilization of the family planning grant award. Family planning nurse consultants are currently developing a comprehensive policy and procedure manual which will be made available to all delegate agencies. The availability of a manual will improve program compliance, consistency in delivery of services resulting in improved quality of service.

TABLE I
INFANT MORTALITY APPROPRIATIONS

| Program | 1986 | 1987 | 1988 | Total |
|---|---|---|---|---|
| Parents Too Soon* | 11,363.2 | 12,040.1 | 13,502.6 | 36,905.9 |
| Prenatal | 3,932.4 | 3,756.0 | 4,884.1 | 12,572.5 |
| Genetics | 440.8 | 470.0 | 470.0 | 1,380.8 |
| Family Planning | 7,218.8 | 7,274.1 | 7,277.6 | 21,770.5 |
| Families with a Future (DPH) | 7,181.0 | 15,561.5 | 15,546.1 | 38,288.6 |
| Public Aid | 4,600.0 | 5,044.0 | 9,000.0 | 18,644.0 |
| Dept. of Children and Family Services | 57.5 | 931.2 | 712.6 | 1,701.3 |
| Dept. of Alcoholism and Substance Abuse | 125.0 | 250.0 | 250.0 | 625.0 |
| State Board of Education | | | 500.0 | 500.0 |
| Perinatal | 4,760.8 | 4,543.8 | 3,543.8 | 12,848.4 |
| TOTAL | 34,918.7 | 45,326.9 | 52,143.0 | 132,388.6 |
| State Funding: | 12,327.0 | 24,890.3 | 28,809.0 | 95,758.6 |

*Includes dollars appropriated to IDPH, IDPA, IDCFS

TABLE II
Infant Mortality Rates: U.S. and Illinois, 1960-1984

| YEAR | DEATHS PER 1,000 LIVE BIRTHS U.S.(1) | ILLINOIS(2) |
|---|---|---|
| 1960 | 26.0 | 25.0 |
| 1965 | 24.7 | 25.7 |
| 1970 | 20.0 | 21.5 |
| 1975 | 16.1 | 18.4 |
| 1980 | 12.6 | 14.7 |
| 1981 | 11.9 | 13.9 |
| 1982 | 11.5 | 13.6 |
| 1983 | 11.2 | 12.3 |
| 1984 | 10.8 | 12.0 |
| 1985 | 10.6 | 11.6 |
| 1986 | N/A | 12.0 |

DRAFT

Illinois Department of Public Health

# 1988
# HUMAN SERVICES PLAN

## PART I - DATA REPORT

Excerpts Pertaining To:

* Special Supplemental Food Program for Women, Infants and Children (WIC)
* Commodity Supplemental Food Program (CSFP)

Volume 7

*A Healthier Today For A Better Tomorrow*

IDPH FY88 HUMAN SERVICES PLAN - PART I

Office of Health Services

Program Title: WIC/CSF Programs

I. Goal

To reduce the prevalence of nutrition-related morbidity and premature mortality in women and young children through modification of eating habits, promotion of good health practices and diet supplementation.

II. Needs Assessment

Nutrition is a critical factor in the promotion of health and prevention of disease. Persons who fail to attain a diet optimal for good health can be found at every socioeconomic level, and the influence on the health of the women, infants and children in the state is seen in:

- The increased risk of poor outcome of pregnancy in the poorly-nourished woman.
- The increased chance that the poorly-nourished women's infant may be of low birth weight with accompanying risk of retarded physical and/or mental development.
- The prevalence of overweight and underweight in children and adults.

In 1985, 180,657 babies were born to Illinois residents. Of those infants, 12,974 were born at low birth weight (LBW) of less than 2,501 grams or 5-1/2 pounds and 2,103 died within their first year of life, resulting in an infant mortality rate (IMR) of 11.6 deaths per 1,000 live births. This reflects a decline from the IMR in 1984 (12.0); however, it still remains higher than the latest estimated National IMR for 1984 of 10.8 per 1,000. The City of Chicago reported for 1985 an IMR of 16.5. The program's income ceiling of 185 percent of poverty level is designed to extend program benefits beyond welfare to the working poor. Table I describes the estimated potential caseload of Women, Infants and Children by Region.

TABLE I
Magnitude of Need
Estimated Potential Caseload of Women, Infants and Children
Per Region According to Income Eligibility*
(in thousands)

| | State Total | Regions 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|---|
| FY87 Estimated | 411.7 | 14.9 | 27.2 | 20.1 | 26.4 | 20.9 | 24.8 | 41.1 | 236.3 |
| FY88 Projected | 411.7 | 14.9 | 27.2 | 20.1 | 26.4 | 20.9 | 24.8 | 41.1 | 236.3 |

* Determination of potential caseload is identified utilizing 1980 census information reflecting 200% of poverty level and 1983 vital statistics.

III. Program Activities

A. The Special Supplemental Food Program for Women, Infants and Children (WIC) and the Commodity Supplemental Food Program (CSFP) are two child nutrition programs which provide nutrition education and prescribed supplemental foods to pregnant and lactating women, infants and children. Both programs address the same population with the exception that CSFP is available to children through five years whereas WIC is offered to children through four years of age. Studies conducted by many institutions have proven that food supplementation positively impacts low birth weight, thus reducing medical costs and infant deaths.

The Division of Health Promotion and Screening has the responsibility for administering the federally funded WIC and CSFP Programs. In order to effectively reach the large population in need of these program services, the responsibility for service provision in WIC is shared with 74 local agencies which serve all counties in Illinois. The CSFP Program currently operates only within the City of Chicago. The WIC and CSFP Programs are funded through two separate federal grants, and therefore, adhere to Federal Rules and Regulations. Program benefits are provided locally to persons who are certified to be at nutritional risk and who meet statewide income eligibility criteria.

The WIC/CSF Programs provide grant funds to local agencies for the delivery of direct services such as health assessments, nutrition education and counselling to eligible clients. Local health professionals determine the nutritional needs of clients and prescribe a food package in the form of food instruments which the client can exchange at the local grocery store. These health services, nutrition counseling and food supplements have a positive and measurable impact on the growth and development of infants and young children.

B. Objectives

1. In fiscal year 1988, to maintain a WIC caseload of 175,000, requesting from USDA sufficient funds to support 160,000 participants per month and utilizing Families with a Future funds to serve the remaining 15,000.

2. In fiscal year 1988, to develop a design to improve the WIC data system and convert to an on-line local agency system.

3. In fiscal year 1988, to continue employing through a consultant contract the consultive services of the Division's Nutrition Section to meet the required nutrition education, technical and resource needs of local agency staff and clients.

4. In fiscal year 1988, to implement recommendations of the study group of local and state agency staff evaluating the service delivery in the City of Chicago.

5. In fiscal year 1988, to identify areas where existing services could be more appropriately and effectively delivered by local public health agencies and foster activities at the local level to effect the transfer of WIC services to such agencies.

6. In fiscal year 1988, to promote a referral network with agencies such as Illinois Department of Public Aid; Children and Family Services; Crippled Children; local school nurses; Parents Too Soon agencies; local hospitals; Families with a Future (FWF) network agencies; the CSF Program; medical care providers; and University of Illinois Extension Service.

7. In fiscal year 1988, implement changes and improvements for the Commodity Supplemental Food Program recommended by the Department Task Force. Expand the Commodity Supplemental Food Program caseload to a monthly caseload of 20,000 clients.

8. In fiscal year 1988, to conduct at least three training programs per region for local agency WIC staff, utilizing regional and central office resources, by September, 1987 to implement the training manual developed in fiscal year 1987 for client masterfile and food instrument procedures.

9. To ensure that at least 75 percent of all vendors receive follow-up training and an on-site monitoring visit during 1987, and to continue during 1988, utilizing regional contractual vendor management staff to complete routine vendor visits and collection of price survey information.

10. In fiscal year 1988, to continue required local agency management evaluations by a team involving Nutrition Services Section staff.

11. In fiscal year 1988, to complete and implement the vendor management data base.

12. During fiscal year 1988, to establish a formal mechanism for vendor organizations to provide input into program operations and policies.

13. During fiscal year 1988, to continue compliance activities with private detective agencies to recover at least $250,000 in vendor overcharges and fraud.

14. In fiscal year 1988, to utilize the data maintained in the personal computer for caseload evaluation, ensuring that highest risk persons are being served and food funds are utilized efficiently.

15. In fiscal year 1988, to fulfill the USDA funding requirement and complete the fiscal year 1989 State Plan of Operation, Policies and Procedures for both the WIC Program and the Commodity Supplemental Food Program.

16. In fiscal year 1988, to include local program staff in the planning and organizing of the Annual WIC Conference.

C. Program Activities

Funding resources for Illinois increased moderately in fiscal year 1987 providing the means to maintain caseload statewide. The tables below describe the number of agencies involved in providing program benefits, the number of food prescriptions provided in 1986 and 1987 by region, and projected service units for fiscal year 1987 and fiscal year 1988.

Activity Measures

| | Actual FY84 | Actual FY85 | Actual FY86 | Estimated FY87 | Projected FY88 |
|---|---|---|---|---|---|
| Activity Measure #1 | | | | | |
| Persons receiving WIC Food Supplements/ month (000s) | 123.8 | 124.2 | 155.8 | 160.0 | 175.0 |
| Activity Measure #2 | | | | | |
| Average monthly number of persons receiving CSFP services (000's) | 2.7 | 6.9 | 12.5 | 12.5 | 20.0 |

Activity Measure #3
Number of Local Agencies Providing WIC and CSFP Services

| | State Total | Regions 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|---|
| FY86 Actual | 76 | 2 | 10 | 14 | 5 | 11 | 9 | 9 | 16 |
| FY87 Estimated | 73 | 2 | 10 | 14 | 5 | 11 | 9 | 8 | 14 |
| FY88 Projected | 73 | 2 | 10 | 14 | 5 | 11 | 9 | 8 | 14 |

Activity Measure #4
Number of WIC Supplemental Food Prescriptions Provided (in thousands)

| | State Total | Regions 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|---|
| SFY86 Actual | 1771.9 | 71.3 | 123.7 | 104.1 | 156.1 | 133.8 | 105.8 | 150.3 | 926.8 |
| SFY87 Estimated | 1929.5 | 73.0 | 122.8 | 101.3 | 150.9 | 141.4 | 111.4 | 161.5 | 1067.2 |
| SFY88 Projected | 2100.0 | 73.0 | 123.0 | 102.0 | 153.0 | 142.0 | 112.0 | 162.0 | 1233.0 |

1. The WIC Program is intended to improve the potential growth and development of infants and children through changing the attitudes and habits of parents, improving parenting skills, and diet supplementation. The WIC Program approaches the eligible individual through the environment of the family unit, teaching parents better eating habits, the relationsnip between health and nutrition, and the vital need for routine preventive health care. Improved habits and skills have a long-range impact not only on the current family unit, but on the generations to come. Training and education of local staff in assessing techniques and sensitivity to the needs of clients will continue to be stressed as a part of our regular training and continuing education programs.

   Much of the success of the WIC Program is the effective delivery of a wide range of services in a variety of settings. The Nutrition Services and WIC/CSF Program staff work together closely to ensure coordination of these critical clinical and administrative services. Annual conferences, grant review, regional meetings and planning sessions for workshop and training courses are organized and coordinated at all levels.

   State and local conferences and workshops will be used as a cost effective and efficient means of communicating to the local programs changes in program policies and procedures, changes in federal regulations or policies, and continuous retraining for data system functions. They will provide continuing education for state, regional and local staff regarding new program initiatives or federally required changes and provide the opportunity for regional and local input into planning and problem resolution.

   Field staff will provide training seminars to new local WIC agencies and to those who, upon review, require guidance to establish compliance procedures. This training will address nutrition education, certification process, fiscal management, use of data processing, caseload management, clinic operation and outreach motivational activities.

2. A major activity of the Illinois WIC Program is grant management, which includes all aspects of funding distribution, cost accountability and monitoring efficient per unit costs. Staff will identify delivery resources for partially unserved areas through surveys of current delivery systems and, where necessary, establish new delivery units. Field staff will assist local programs in developing initial applications; in securing timely and proper agreements with local agencies which are approved for funding; assisting local agencies with budget development and financial problem solving; and providing assistance to local staff in program and caseload management.

Field staff will review the assignment of staff in local agency administrative functions and clinic operation, assess the efficiency of the staffing pattern and offer assistance in more effectual service delivery.

In an effort to contain the administrative cost of the program, staff will continue to review various aspects of the program operation to determine if cost-efficient alternatives exist and can be implemented. This investigation will include close review of staff-sharing, and multi-county expansions.

3. In the summer of 1986, an investigative study of the future data processing needs of the WIC Program was completed by Arthur Young International. This study defined alternatives and parameters for future actions. In December 1986, an Application Transfer Study was initiated by Department staff which described a general design for an on-line local agency data system. This study further defined the system functions, operations and implementation calendar.

   During fiscal year 1988, two active committees will begin work on the detail design and testing of the new system:

   - the Steering Committee of administrative staff will oversee the project and direct its completion; and

   - the Implementation Committee consisting of state, regional and local staff, will work in conjunction with the design consultant to develop a realistic system design that meets the needs of both the state and local level.

   Bid specifications will be prepared and a consultant hired by January 1988 to begin work on the system detail design.

4. Federal regulations specify minimum standards for routine and ongoing program evaluation. Total program operation is evaluated at least once a year through composites of field staff local site visit reviews. Areas specifically addressed for this evaluation process include: effectiveness of the administrative structure in developing and attaining program goals and objectives, and appropriateness of staff assignments, considering individuals' education and background.

   Ongoing program reviews will be accomplished by utilizing data system output reports, phone contacts and site visits to assess the food delivery system. More formal guidelines and procedures are being implemented with clearer definitions and time frames for follow-up actions.

Routine site visits will be conducted by regional and central staff, who will provide technical assistance to new and current staff. These site visits will be address recommendations and corrective actions documented from previous visits, or will be conducted as a part of the annual evaluation process. Where feasible, personal visits are eliminated in favor of phone contacts or letters.

During routine local agency site visits, staff will review actual clinic procedures to determine the treatment of participants in the service delivery system. This will monitor compliance with required state and federal procedures for participant eligibility, and evaluate documentation of participant eligibility criteria and proper record maintenance.

5. The possibility of error, waste and fraud by WIC vendors requires an effective means of monitoring redemption practices and billing activities. Staff will monitor vendors and assure that the vendor understands the intent of the program, state and federal rules and policies and complies with specified rules and policies, as defined in the vendor agreement. This will be accomplished through data system reviews and on-site visits.

   Staff will continue to develop more definitive policies and procedures for vendor selection and application. Emphasis will be placed on preventing vendors with a history of questionable business practices from participating in the program.

   Staff will monitor contract compliance by reviewing vendor redemption and billing practices and documenting compliance site visits. In addition, staff will continue to cooperate with federal authorities in the identification or suspension of vendors abusing the system.

   Documenting evidence for abuses and sanctions will be accomplished by staff at each site visit through interviews with participants or local agency personnel, through the accumulation of past billing documents, and the information documented by private detective agency personnel in compliance activities.

6. During fiscal year 1988, strong emphasis will continue to be placed on quality caseload management by stressing the need to increase the number of qualified nutritionists serving as primary screeners, mandating attendance by local staff at workshops, addressing inefficiency of clinic operation by no-show rates, and implementing an improved and revised risk criteria system to ensure accurate assessments to serve highest risk clients.

7. The Department's Division of Audits will perform a fiscal audit of all local agencies at least once every two years. The report of this audit will be transmitted to the program staff to assist and monitor local agencies in resolving outstanding issues.

IV. Program Effectiveness

In 1985-87 a major initiative was undertaken to expand services in the city of Chicago by involving community based health agencies. Four new local programs began operation in the summer of 1985 and another in March 1986. The local service expansion has increased the current monthly caseload by 10,000 persons. With this expansion and the continued emphasis on services in Chicago, more than 80,000 persons in Cook County are receiving WIC benefits. Also, this WIC expansion serves as an outreach to high-risk pregnant women to motivate early entry in the health care system. Specific information on caseload growth statewide is included in the Program Activities section.

The Commodity Supplemental Food Program (CSFP) continued to be offered only in the City of Chicago during federal fiscal year 1987. The Catholic Charities of the Archdiocese of Chicago has been awarded a continuing grant in fiscal year 1987 to operate the CSFP. The program provided food supplementation and nutrition education to an average monthly caseload of 12,000 individuals by September 30, 1986. Extensive outreach efforts have been organized with other health service agencies to increase the effectiveness of referral programs.

During 1986 and 1987, special funds were provided to a select group of local agencies through the Families with a Future to increase the number of high risk pregnant women and infants receiving services. These projects addressed innovative ways to reach high risk eligibles and to enhance nutrition activities.

During 1986, a service delivery evaluation project for Chicago studied access to required medical evaluation, client processing, clinic flow and operational problems. During fiscal year 1987, the study group completed a report proposing recommendations to maximize effectiveness and efficiency of services, increase cost effectiveness and better address client needs.

During 1986, the Vendor Relations Unit continued a statewide training program for vendors and was very successful in the identification of high risk vendors. Such vendors' practices were evaluated by private detective agencies during compliance activities. Sanctions and terminations were imposed on 62 vendors during 1986, and 95 new investigations were initiated. The Department realized $259,143 in vendor recoveries during 1986.

Revised program review procedures for local service agencies allow more flexibility in the management review process, increasing the consultive value of evaluations. The positive follow-up outcome provided improved documentation for use during local agency grant review and allocation of available funds.

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Significant training and education activities were made available to local agency staff in the form of workshops, seminars and consultations provided by regional and central staff on topics of nutrition, financial management, client master file maintenance, caseload management, and clinic flow and operation. In addition, the third annual WIC conference was very successful in providing a forum for local agency informational exchange and interaction.

During 1986 and 1987, control of caseload management continued to improve through local agency reporting, management consultation by field staff and monthly review of utilized caseload reallocation. In addition, the Illinois program was able to increase caseload in spite of increased food costs.

In fiscal year 1987, two additional county health departments became WIC providers. The comprehensive health services available from health departments complements the scope and nature of food supplementation in the most effective way.

During fiscal year 1986 and fiscal year 1987, a system analysis and needs assessment for WIC Program data processing was completed. In addition, a general design of a new proposed system was completed by Department staff. This project defines the scope, cost and implementation schedule for the next three years.

V. Assurances

A. Interagency Cooperation

The intent of the WIC/CSF Programs is to work in conjunction with available public health programs at the local level. Local agencies providing services must organize service delivery systems that will most effectively interface with other program resources, such as: well child; prenatal; immunization; family planning; Parents Too Soon; and Families with a Future. In the process of integrating with other health services, local agencies must also work closely with other social service agencies in the community for maximizing the referral network: Public Aid, Children and Family Services; Crippled Children; school nurses and community social programs for serving the indigent population.

B. Family Impact

The WIC/CSF Programs provide a unique service to families at a critical time in the growth and development of family members. Special attention is given to helping parents understand the importance of routine health care, adequate nutrition and parenting skills for the proper growth and development of children. Both programs can thereby reduce the number and severity of children with significant and chronic illnesses.

VI. Recommended Changes to Program

No significant program changes are anticipated in fiscal year 1988.

VII. Legal Citations

Child Nutrition Act of 1966, as amended by P.L. 95-627 (Nov. 10, 1978) and P.L. 96-499 (Dec. 5, 1980).

0346b/SP-85N

Illinois Department of Public Health

# BIRTH CERTIFICATE SURVEY ON ACCESS TO PRENATAL AND WELL CHILD CARE

*A Healthier Today For A Better Tomorrow*

# BIRTH CERTIFICATE SURVEY ON ACCESS TO PRENATAL AND WELL CHILD CARE

## INTRODUCTION

Numerous studies have established that prenatal care can favorably affect infant survival and health. Even when controlling for all other factors, receiving adequate prenatal care greatly reduces infant mortality and morbidity as well as the economic, social and personal costs. Prenatal care has been shown to decrease the incidence of low birth weight babies, a condition associated with cerebral palsy, mental retardation, learning disabilities, and other developmentally disabling conditions. In addition to mortality and low birth weight, another factor that greatly influences the quality of life is fetal stress associated with the birth experience. It has been demonstrated that infants experiencing such stress have a higher incidence of placement in special education classes and lower IQs, and that some stress factors such as toxemia can be significantly reduced through prenatal care.

National data show no shift toward early prenatal care and away from late or no prenatal care since 1978. Infant mortality has decreased nationally, but the non-white rate still greatly exceeds that of whites. In Illinois this gap is actually widening. Illinois' vital statistics for 1985 show that 4.5% of women received late or no prenatal care statewide with 6.9% receiving such inadequate care in the City of Chicago. The balance of the state showed 22 counties with the percentage of women receiving late or no prenatal care meeting or exceeding the State average. Further, Illinois' percent of low birth weight infants (7.2) exceeds that of the National rate of 6.8 (1982). Lack of access to or under utilization of prenatal services increases the occurrence of morbidity and death. Infant mortality in Illinois is 11.6 per 1,000 live births which exceeds the National rate of 10.9 (1983 - last data available estimated). Thirty counties in the downstate area meet or exceed the State infant mortality rate. Postneonatal mortality in the State is 3.9 per 1,000 live births with Chicago at 6.0.

The Illinois Department of Public Health has funded prenatal services in Chicago since 1964 and on a limited basis in the downstate area since 1980. Despite these efforts there remain about 8,000 women per year delivering infants after receiving little or no prenatal care. Before expanding its efforts in this area, it was critical for the Department to discover the underlying reasons why women were receiving inadequate prenatal care.

Anecdotal reports from the currently funded projects suggested that the reasons for inadequate utilization of prenatal care were varied and would require individualized approaches within communities depending on the problems

identified. Suggested reasons included: insufficient funds/ insurance; lack of physicians willing to accept Public Aid clients; belief that prenatal care is unimportant; lack of transportation; lack of bilingual services; dissatisfaction with present services; religious beliefs that medical care is unacceptable. Although provision of prenatal care has been associated with significant decreases in infant mortality, access to well child care is also a factor in reducing this rate.

## MATERIALS AND METHODS

In order to discover what the underlying access problems actually were and to develop appropriate strategies to address them where possible, the Department needed accurate documentation. To accomplish this, the Department undertook a survey of women who had received little or no prenatal care. The survey was partially funded under a grant from the Governor's Planning Council on Developmental Disabilities (GPCDD). A survey tool was adapted from one used by the Michigan Perinatal Association for a similar survey done in 1983. The instrument and the cover letter were revised to an eighth grade reading level using the PROF Computer System. All live birth certificates were pulled for women delivering infants between October 1, 1984 and September 30, 1985, who had received late (i.e., third trimester registration) or inadequate prenatal care or no prenatal care at all. Initially, inadequate care was defined as having less than six visits. After the first month's return, the number of visits was reduced to four or less since it was noted that most women reported at least four more visits than were recorded on the birth certificate.

Once the certificates were pulled, those coded as being subsequently associated with an infant death or an adoption were eliminated. The remainder of the women were contacted via the mailed survey. In order to enhance response, it was decided not to ask demographic information which could be obtained from the birth certificate. Instead, the birth certificate code number was placed on the survey tool in order to later match each survey with the corresponding birth certificate. Pre-paid return envelopes were included with the survey and anonymity was assured.

Because there was concern that the nonresponders might have different attitudes and needs than the responders, the

Department decided to have public health nursing agencies in targeted areas with high rates of infant mortality conduct home visits to a two month sample of nonresponders. In addition to conducting the routine maternal and infant visits/and linking the families with needed services, the public health nurses were asked to obtain the additional information needed for the survey. Since anonymity was assured, we used the agencies who were the local registrars and requested that the purpose of the visit be related to the Infant Mortality Reduction Initiative (IMRI: a special programming initiative in Illinois targeted in areas with high rates of infant mortality) rather than the survey. A total of 491 surveys were completed at the time of public health nursing home visits.

All precoded survey data were entered into a computer program on the Department's mainframe. This file was matched and merged with the Birth Certificate work file for the 12 month period of the survey and reports for analysis were generated through the Division of Data Processing.

Conducting the survey cost approximately $57068.50. (Appendix J) This included expeditures for supplies, postage, contractual services and indirect costs at the Department.

## Prenatal Care Results

A total of 16,224 surveys were distributed. Of this number 29% were completed and 11% were returned as undeliverable. Demographics for those responding versus those who did not respond or who had this survey returned as undeliverable were comparable statewide except for race and marital status. These variations were less marked for the Chicago area than for the Statewide totals. There was a 26% agreement between the birth certificate data and the survey on trimester of registration for care and an 18% agreement on number of visits. In general, birth certificates reported less care.

Of those responding 86% received prenatal care and 13% did not. Of those receiving prenatal care, 33% received between 1 and 6 visits, 30% received 7 to 11 visits, 26% received 12 or more visits and 11% received an unknown number of visits. Of those responding, 51% registered in the first trimester, 33% in the second trimester, 12% in the third trimester with 12% seeking care within the first month. Women reported waiting less than 1 week to be seen after calling for an appointment 27% of the time, between 1 week and 1 month 56% of the time, between 2 months and 3 months 3% of the time and 4 months or more less than 1% of the time.

The majority of respondents felt prenatal care was important (95%) with only 2% feeling it was only slightly important and 1% feeling it was not important at all. Of those responding, 51% reported that they could have used help in obtaining prenatal care. Of those responding, 48% of the respondents identified specific problems they encountered which delayed their access to prenatal care. Of these women, 66% reported only one problem with the breakout being 35% finances, 8% family problems, 6% finding a physician who would take Title XIX, 9% lack of transportation and 8% some other problem. Two or more problems were reported by 29% of these women as being encountered when attempting to access care. Within this group 76% had financial problems, 30% had family problems, 53% had transportation problems, and 23% had physicians refuse their Public Aid coverage. In addition, 32% reported miscellaneous problems.

Over half of the patients reported receiving their care from an obstetrician (67%), 19% from their family doctor, 7% from nurse midwives, 3% from public clinics, 4% from multiple providers and less than 1% from other types of providers. More women reported vendors to cover expenses than reported receiving prenatal care, so only the distribution for total responders was reviewed. The care received was exclusively covered by a single vendor for 78% of the responders with the breakout being Title XIX for 34%, insurance for 13%, cash for 11%, free public clinics for 9%, HMO's for 4%, and loans for 1%, with 5% reporting simply not paying their bills. Ten percent reported using two or more mechanisms to pay for their care.

As was the case in reporting data regarding vendors, more women reported mode of transportation than reported receiving prenatal care, so only data for the total group of responders was reviewed.

Of the women responding, 45% reported driving as their means of travel to appointments, 10% walked, 22% rode public transit and cabs/miscellaneous other modes were reported by 1%. Ten percent reported using 2 or more modes of travel. In regard to distance traveled for care, 46% traveled five miles or less, 23% between 6 and 15 miles, 9% between 16 and 30 miles, 3% between 31 and 50 miles, and 0.6% more than 50 miles or more.

For women who reported problems in accessing prenatal care, significant differences were noted within subsets of the population as to which problems were most frequently

encountered. Married women were more likely to report financial problems, while unmarried women were more likely to report family and transportation problems. Women aged 20 and over reported financial problems slightly more often, while teens reported more family problems. Teens reported encountering problems slightly more often than older women. Whites, Orientals and other non-whites reported financial problems more frequently, while blacks reported more transportation problems. Orientals and Blacks reported encountering no problems more often than whites. Women having their first child reported more family problems, while women with other living children reported more travel and combined problems.

Attitudes towards the importance of prenatal care varied little by race, marital status, and age. Married women reported relying on private insurance and cash payments more frequently while unmarried women reported relying on Title XIX and free clinics more frequently. Women 20 and over reported more frequent reliance on insurance, while teens reported relying on free clinics and Title XIX more often. Whites and Orientals reported relying on private insurance and cash more often, while Blacks reported relying on Title XIX and public clinics more frequently. Women reported seeking care slightly later in pregnancy if they were unmarried or adolescent or Black or Oriental. Financial problems, family problems, transportation problems and problems finding a physician who would accept Title XIX were associated with the greatest delays in initially seeking care. Women who reported relying on cash, loans and free clinics reported longer waits for initial appointments for prenatal care. Low birthweight infants occurred more frequently in women who reported family or combined problems and in women who reported relying on private insurance.

Of those who reported receiving care, 82% reported receiving physical exams, 37% WIC, 30% general prenatal education, 25% prepared childbirth education, 21% diet counseling, 19% public health nursing home visits after delivery, 15% social worker counseling, and 6% prenatal public health nursing home visits. For 25% of the women referrals were made to family planning services after delivery and 27% to well baby clinics.

## Well Child Care

Of those responding, 94% reported having living children, 4% reported infant deaths and less than 1% reported having placed the infant for adoption. Of those responding, 95% felt

that well child care was important. Of those who felt it was not, 90% felt that you only needed to see the doctor when ill, 11% felt it was against their religion, and 16% reported miscellaneous other reasons that it was not important.

Of those reporting care from a single provider source, the breakout was 43% from a pediatrician, 24% from health department clinics, 15% from hospital clinics, 5% from HMO's, and 6% from miscellaneous other sources. Six percent reported using multiple sources for care.

Problems in accessing well child services were reported by 14% of the respondents. Of those reporting problems, 42% reported inability to pay as a problem, 26% reported inability to find a physician to accept Title XIX, 24% reported lack of transportation, and 8% reported miscellaneous other problems.

Of those with live children, 79% of the mothers reported that their children were receiving physical exams, 84% immunizations, 46% WIC, 10% public health nursing home visits, 1% Crippled Children's Services, 2% EPSDT(Medichek), 10% developmental testing, 2% 0-3 services, 1% special education services, and 2% miscellaneous other services.

## DISCUSSION

Despite efforts to avoid contacting women whose infants died or who placed them for adoption, some were inadvertently contacted. Of 109 letters received from responders along with their survey, 20 were from women who fell into this group. Letters of apology were sent to these families. Sixty-four of the letters related to requests for additional information or assistance in regard to MCH services.

The first month the survey went out the cover letter acknowledged that the women receiving the survey had received inadequate prenatal care. Twenty-five letters and nine phone calls were received by the Department stating that there had been an error. In order not to upset women who might have had adequate care, the letter was reworded to delete reference to the survey group being a select population and the number of visits was revised as mentioned earlier. This seemed to eliminate this particular problem.

In light of the variations within subsets of the population with regard to problems being encountered while accessing prenatal care and well child services, it appears as

though some resolutions will need to be tailored to meet the needs of specific subgroups while others can be addressed more broadly. At present the Department is funding a number of Prenatal Programs for the medically indigent, and plans are underway to expand this effort under the Infant Mortality Reduction Initiative (IMRI). It is hoped that these programs which include all basic service components will eventually be available statewide. Transportation is being covered for clients in some of these programs and is a service component which is to be addressed under IMRI in targeted communities. The existing Prenatal Projects, as well as the IMRI Networks, provide case management for enrolled clients which should facilitate resolution of some access problems. These systems should also be able to improve the comprehensiveness of the services provided. Based on the services described as being received by women who responded the packages which they and their children now receive are inadequate. Problems need to be identified as to why physicians will not accept Title XIX clients and resolutions need to be sought jointly through the Department of Public Aid and the Illinois State Medical Society.

Survey results suggest that women know prenatal and well child care are important but need assistance in accessing these services. The Prenatal Hotline being developed under IMRI is designed to help families locate the services they need. For those living in areas where IMRI networks and/or Prenatal Projects are located, they will be linked with case management systems. MCH Directories developed by the Illinois Public Health Association under a grant from the Governor's Planning Council on Develpmental Disabilities (GPCDD) are being disseminated to consumers and providers statewide. Additionally,the GPCDD has funded the purchase of MCH materials for distribution to consumers at local Developmental Disabilities Prevention Fairs to be held in the spring of 1987 in conjunction with IMRI activities. Hopefuly these two activities will facilitate consumer knowledge of and access to services statewide.

Data are being provided to local jurisdictions on survey results for women residing in their area. This should act as a catalyst to problem solving on a local level, especially for those problems which cannot easily be addressed on a statewide basis.

LIST OF APPENDICES


Request for Access to Vital Records A

Confirmation of Access to Vital Records B

Cover Letter Number 1 C

Final Cover Letter D

Statistical Profile of Responders E

Sample Survey With Composite Responses Statewide F

Summary Tables of State-wide Responses G

1. Attitude Toward Prenatal Care by Maternal Age
2. Delay in Seeking Care by Maternal Age
3. Problems in Accessing Prenatal Care by Maternal Age
4. Vendor by Maternal Age
5. Attitude Toward Prenatal Care by Maternal Race
6. Problems in Accessing Prenatal Care by Maternal Race
7. Vendor by Maternal Race
8. Delay in Seeking Care by Maternal Race
9. Attitude Toward Prenatal Care by Marital Status
10. Delay in Seeking Care by Marital Status
11. Problems in Accessing Prenatal Care by Marital Status
12. Vendor by Marital Status
13. Vendor by Problems in Seeking Prenatal Care
14. Vendor by Wait for Appointment
15. Vendor by Birthweight
16. Problems in Accessing Prenatal Care by Delay in Seeking Care
17. Problems in Accessing Prenatal Care by Birthweight
18. Problems in Accessing Prenatal Care by Number Prior Living Children
19. Problems in Accessing Prenatal Care by Mode of Transportation
20. Problems in Accessing Prenatal Care by Distance Traveled

Breakout of Combined Problems H

Consumer Contacts Requiring Department Response I

Comparison Between Survey Response and Birth Certificate Data J

Project Budget K

Bibliography L

APPENDIX A

September 28, 1984

MEMORANDUM

TO: Aaron Vangeison, Chief
Division of Vital Records

FROM: Elsie Sata Baukol, M.D., M.P.H.
Chief, Division of Family Health

SUBJECT: Request for Access to Birth Certificates

As discussed with you in a meeting on September 21, the Division of Family Health has recently received a grant from the Governor's Planning Council on Developmental Disabilities to survey women who received little or no prenatal care in order for us to plan and target efforts toward improving access to and/or utilization of prenatal services in the State. This survey will be done in two stages: initial contact of all women in this category for completion of the questionnaire; follow-up using home visits by public health nurses under contract with the Department to a targeted subset of the non-responders who are in areas of high underutilization. Confidentiality of the client-specific information obtained will be assured throughout the process.

The details of the project implementation, which were touched upon in our initial discussion, will be finalized once approval has been obtained for my Division to access the necessary certificates. If possible we would like to see the project start up with certificates for births occurring on October 1, 1984. The project is anticipated to run exactly 12 calendar months.

As requested, a draft of the cover letter for initial maternal contact is attached. Please advise me as soon as possible of your decision.

ESB:DM/3745w/L

Attachment

cc: D. Mertens

APPENDIX B

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Fred H. Uhlig, Acting Director
535 West Jefferson Street • Springfield, Illinois 62761 • Telephone 217-782-4977

Reply to:

October 9, 1984

PUBLIC HEALTH

OCT 12 1984

Div. of Family Health

MEMORANDUM

TO: Elsie Sata Bankol, M.D., M.P.H.
Chief, Division of Family Health

FROM: Aaron Vangeison, Chief
Division of Vital Records

SUBJECT: Access to Birth Certificates

I have obtained authorization for a member of your staff to have access to the birth records to determine pre-natal care as reported on the records.

Please contact Elizabeth Vincent of my staff (785-1054) after October 22nd to make arrangements for someone to locate and copy the records needed.

cc: Diana Mertens

APPENDIX C

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Thomas B. Kirkpatrick, Jr., Director
535 West Jefferson Street • Springfield, Illinois 62761 • Telephone: 217/782-4977
160 North LaSalle Street • Chicago, Illinois 60601 • Telephone: 312/793-2793

Reply to:

Dear New Mother:

The Illinois Department of Public Health has been attempting to make it easier for pregnant women and children throughout the State to obtain services. In order for us to do this better, we need to find out what problems exist which keep people from getting care. To do this we need your help. As the State Agency responsible for registering vital records, all birth certificates are sent to us for permanent filing. At the bottom of the certificate there is a section which provides information on care to pregnant women. This information is confidential and is used only for Department statistics. Your certificate indicated that you received little or no care during your pregnancy. For this reason we are asking you to complete the attached form and return it in the enclosed envelope, so that we can help make services available to all families in your area desiring them. Your response will be completely confidential so please be honest. Your help in obtaining this information can have a significant and positive impact on the lives of many mothers and children in Illinois.

Thank you for helping us.

Sincerely,

Thomas B. Kirkpatrick, Jr.
Director

NB: This version of the letter was used only for October, 1984 births included in the survey.

APPENDIX D

STATE OF ILLINOIS

DEPARTMENT OF PUBLIC HEALTH
Bernard J. Turnock, M.D., M.P.H
Director

Dear New Mother:

The Illinois Department of Public Health has been attempting to make it easier for pregnant women and children throughout the State to obtain services. In order for us to do this better, we need to find out what problems exist which keep people from getting care. To do this we need your help. As the State Agency responsible for registering vital records, all birth certificates are sent to us for permanent filing. According to our records you recently delivered a baby. Therefore, we are asking you to complete the attached form and return it in the enclosed envelope, so that we can help make services available to all families in your area desiring them. Your response will be completely confidential so please be honest. Your help in obtaining this information can have a significant and positive impact on the lives of many mothers and children in Illinois.

Thank you for helping us.

Sincerely,

Elsie S Baukol M.D.

Elsie Sata Baukol, M.D., M.P.H.
Chief, Division of Family Health

Attachments

535 West Jefferson Street • Room 450, Springfield, Illinois 62761 • (217) 782-4977
100 West Randolph Street • Suite 6-600, Chicago, Illinois 60601 • (312) 793-2793

APPENDIX E

PROFILE OF WOMEN SURVEYED BY CATEGORY OF RESPONSE

| | ADOPTIONS/ NO RESPONSE | UNDELIVERED/ MOVED/RETURNED | RESPONDED/ NURSE VISIT (491) |
|---|---|---|---|
| MATERNAL AGE | | | |
| 14 & Less | 103 (1%) | 20 (1%) | 45 (1%) |
| 15-17 | 1157 (12%) | 181 (10%) | 561 (12%) |
| 18-19 | 1595 (16%) | 292 (18%) | 685 (15%) |
| 20-29 | 5379 (55%) | 1035 (59%) | 2660 (56%) |
| 30-39 | 1424 (15%) | 209 (12%) | 722 (15%) |
| 40 & Up | 96 (1%) | 9 (<1%) | 48 (1%) |
| NA | 0 | 1 (<1%) | 2 (<1%) |
| MATERNAL RACE | | | |
| White | 5400 (55%) | 942 (54%) | 2851 (60%) |
| Black | 4171 (43%) | 765 (44%) | 1795 (38%) |
| Oriental | 150 (2%) | 31 (2%) | 66 (1%) |
| Other | 27 (<1%) | 9 (<1%) | 9 (<1%) |
| NA | 6 (<1%) | 0 | 2 (<1%) |
| MARITAL STATUS | | | |
| Married | 4141 (42%) | 612 (35%) | 2193 (46%) |
| Unmarried | 5605 (58%) | 1135 (65%) | 2529 (54%) |
| NA | 8 (<1%) | 0 | 1 (<1%) |
| MONTH OF REGISTRATION | | | |
| 1-3 | 2127 (22%) | 380 (22%) | 1048 (22%) |
| 4-6 | 2421 (25%) | 423 (24%) | 1191 (25%) |
| 7-9 | 2998 (31%) | 506 (29%) | 1587 (34%) |
| None | 1127 (12%) | 252 (14%) | 385 (8%) |
| NA | 1081 (11%) | 186 (11%) | 512 (11%) |
| BIRTHWEIGHT | | | |
| 500gm & Less | 61 (1%) | 4 (<1%) | 32 (1%) |
| 501-1500 | 338 (3%) | 51 (3%) | 136 (3%) |
| 1501-2500 | 1009 (10%) | 205 (12%) | 521 (11%) |
| 2501 & Up | 8213 (84%) | 1460 (84%) | 3951 (84%) |
| NA | 133 (1%) | 27 (2%) | 63 (1%) |
| TOTALS | 9754 (60%) | 1747 (11%) | 4723 (29%) |

Source: Birth Certificate Work File pulled from Vital Records for October 1, 1984 through September 30, 1985, IDPH

STATEWIDE RESULTS

APPENDIX F

n = 4723

## Prenatal Questionnaire

*Prenatal care is medical care for women who are pregnant.

Section I. Mother

1. Did you receive prenatal care during your pregnancy?

| | | | | |
|---|---|---|---|---|
| 4067 (86%) Yes | 627 (13%) No | 28 (1%) NA | 1 (<1%) Adoption | |

2. For women in general, how important do you feel it is for them to receive prenatal care?

| | | |
|---|---|---|
| 3834 | Very important (81%) | |
| 660 | Important (14%) | 4588 (97%) |
| 94 | Only slightly important (2%) | |
| 25 | Not important at all (<1%) | |
| 64 | No opinion (1%) | 110 (2%) |
| 46 | NA (1%) | |

3. Could you have used help in obtaining prenatal care?

| | | |
|---|---|---|
| 2405 (51%) Yes | 2135 (46%) No | 163 (<1%) NA |

4. What problems, if any, delayed you in seeking prenatal care?

| % Total with Prob. | | |
|---|---|---|
| | 2313 | None (49%) |
| 35% | 840 | Financial problems (18%) |
| 8% | 198 | Family problems (4%) |
| 6% | 138 | Couldn't find physician to take a green card (Public Aid) (3%) |
| 9% | 219 | Lack of transportation (5%) |
| 8% | 186 | Other, please describe (4%) _____ |
| 29% | 689 | Combined (15%) |
| | 140 | NA (3%) |

If you did not receive prenatal care please skip to Section II on infants, otherwise please continue.

| % Total in Care | |
|---|---|
| 12 | 1-501 (11%) |
| 22 | 2-912 (19%) |
| 17 | 3-709 (15%) |
| 13 | 4-521 (11%) |
| 11 | 5-451 (10%) |
| 9 | 6-376 (8%) |
| 8 | 7-310 (7%) |
| 3 | 8-118 (2%) |
| 1 | 9-34 (1%) |
| None-627 (13%) | |
| NA-254 (5%) | |

5. In what month of pregnancy did you begin prenatal care?

_____ month (first, second, etc.)

6. Approximately how many visits did you make during your pregnancy? (33%) 1-6 1332 (28%) (26%) 12+ 1069 (23%) (30%) 7-11 1225 (26%) None-627 (13%) NA-470 (10%)

7. How many weeks or months did you know you were pregnant before you sought prenatal care?

____ weeks ____ months

| % Total in Care | |
|---|---|
| 26% | 1wk-1mo 1051 (22%) |
| 41% | 5wk-3mo 1679 (36%) |
| 22% | 13wk-6mo 894 (19%) |
| 7% | 27wk-9mo 280 (6%) |
| | None 627 (13%) |
| | NA 192 (4%) |

8. How long did you have to wait to be seen after you called for your first appointment? (27%) <1wk-1086 (23%)
None-627 (13%) (56%) 1wk-1mo-2279 (48%)
___ Days ___ Week NA-620 (13%) (3%) 2-3mo- 104 (2%)
(<1%) 4mo+- 7 (<1%)

% Total in Care

46% 1-5mi 1864 (39%)
23% 6-15mi 932 (20%)
9% 16-30mi 347 (7%)
3% 31-50mi 102 (2%)
<1% 51-100mi 21 (<1%)
<1% over 100 5 (<1%)

9. How far did you have to travel to receive prenatal care (that is the distance between your home and the office or clinic where you received care)? ___ Miles

10. How did you usually get to your office visits?

12% 482 Walked (10%)
30% 1229 Drove (26%)
22% 897 Family member/friend drove (19%)
25% 1029 Public transportation (22%)
10% 39 Cab (1%)
1% Other, please describe 7 (<1%)
11% 460 Combination (10%) None-580 (12%)

11. Who provided your care?

% Total in Care

67% 2733 Obstetrician (specialist who delivers babies) (58%)
19% 781 General Practitioner/Family Doctor (17%)
7% 265 Nurse-Midwife (6%)
<1% 19 Lay Midwife (<1%)
3% Other, please describe 130 ( 3 %)
4% 170 Combination (4%) None 625 (13%)

12. How did you pay for the prenatal care you received during this pregnancy?

% Total in Care

15% 615 Insurance (13%)
5% 198 HMO (4%)
39% 1593 Medicaid (Green card) (34%)
13% 518 Cash (11%)
11% 436 Free public clinic (9%)
1% 26 Loan (1%)
5% 221 Unable to pay (5%)
1% Other, please describe 49 (1%)
12% 487 Combination (10%) NA 580 (12%)

13. Please indicate which of the following services you received during your pregnancy.

% Total in Care

25% 1005 Prepared childbirth (for example Lamaze) (21%)
82% 3328 Physical exams by the doctor or nurse midwife (70%)
37% 1496 WIC (32%)
21% 866 Diet counseling (18%)
15% 621 Social worker counseling (13%)
6% 229 Public health nursing home visits before delivery (5%)
19% 768 Public health nursing home visits after delivery (16%)
30% 1228 General prenatal education (26%)
25% 1017 Referral to family planning after delivery (22%)
27% 1107 Referral to well baby clinics after delivery (23%)
NA 46 (1%)
None 627 (13%)

Section II. Infants

1. Do you have living children?

4463 Yes (94%) 174 No (4%) 17 Adoption (<1%) 69 NA (1%)

If you do not, please send the completed questionnaire back in the enclosed envelope. Thank you for your help. If you do, please go on to question #2.

2. Do you think well child care is important?

4472 Yes (95%) 58 No (3%) 193 NA (4%)

If your answer is no please list the reasons for this belief:

27 Against your religion to go to doctors. (11%)
227 Only go to a doctor when ill. (90%)
Other, please describe 19 (16%)

3. Where is your child getting medical care?

| % Living Child | | |
|---|---|---|
| 43% | 1923 | Private pediatrician (baby doctor) (41%) |
| 5% | 212 | HMO (5%) |
| 15% | 689 | Hospital clinic (15%) |
| 24% | 1079 | Health Department clinic (23%) |
| 6% | | Other, please describe 270 (6%) |
| 6% | 258 | Combination (5%) |
| | | NA 267 (6%) |

4. Did you have any problems finding medical care for your child?

679 Yes (14%) 3812 No (81%) 232 NA (5%)

5. If you had no problems skip to question #6. If you had problems, please indicate which were the main ones:

382 Unable to pay (42%)
232 Couldn't find a doctor who would take a green card (Public Aid) (26%)
218 Lack of transportation (24%)
Other, please describe 73 (8%)

6. Please indicate which of the following services your child is receiving:

| | | % Total with Living Child |
|---|---|---|
| 3522 | Physical exams by the doctor | (79%) |
| 3732 | Immunization (well baby shots) | (84%) |
| 2055 | WIC | (46%) |
| 453 | Public Health Nursing Home Visits | (10%) |
| 47 | Crippled Children's Services | (1%) |
| 98 | Medichek (EPSDT) (2%) (6% of those reporting Title XIX vendor) | |
| 468 | Developmental testing (special testing to see if your baby is developing normally) | (10%) |
| 74 | Infant stimulation/0-3 services | (2%) |
| 37 | Special education services | (1%) |
| | Other, please describe 76 (2%) | |
| 731 | NA (16%) | |

Please return the questionnaire in the envelope enclosed. Thank you very much for your help.

DM/6271w/k
Enclosure

APPENDIX 6

TABLE 1

Distribution of Attitude Toward Prenatal Care
Within Maternal Age Groupings

| ATTITUDE | Teen | | Adult | | NA |
|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number |
| Very Imp | 1011 | 78 | 2822 | 82 | 1 |
| Imp | 199 | 15 | 460 | 13 | 1 |
| SI Imp | 30 | 2 | 64 | 2 | 0 |
| Not Imp | 10 | 1 | 15 | 0.5 | 0 |
| No Op | 26 | 2 | 38 | 1 | 0 |
| NA | 15 | 1 | 31 | 1 | 0 |
| Total | 1291 | 100 | 3430 | 100 | 2 |

TABLE 2

Distribution of Delay in Seeking Care
Within Maternal Age Groupings

| DELAY | Teen | | Adult | | NA |
|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number |
| WK-Mo | 204 | 16 | 847 | 25 | 0 |
| Five-3M | 423 | 33 | 1255 | 37 | 1 |
| Four-6M | 302 | 23 | 592 | 17 | 0 |
| Seven-9M | 94 | 7 | 186 | 5 | 0 |
| NA | 268 | 21 | 550 | 16 | 1 |
| Total | 1291 | 100 | 3430 | 100 | 2 |

Table 3

Distribution of Problems in Accessing Prenatal Care
Within Maternal Age Groupings

| PROBLEM | Teen | | Adult | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| None | 595 | 46 | 1718 | 50 |
| Financial | 213 | 16 | 626 | 18 |
| Family | 112 | 9 | 86 | 3 |
| Title XIX | 37 | 3 | 101 | 3 |
| Travel | 76 | 6 | 143 | 4 |
| Other | 51 | 4 | 136 | 4 |
| NA | 32 | 2 | 108 | 3 |
| Combined | 175 | 14 | 513 | 15 |
| Total | 1291 | 100 | 3430 | 100 |

Table 4

Distribution of Vendor Within Maternal Age Groupings

| VENDOR | Teen | | Adult | | NA |
|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number |
| Insurance | 102 | 8 | 513 | 15 | 0 |
| HMO | 38 | 3 | 160 | 5 | 0 |
| Title XIX | 471 | 36 | 1125 | 33 | 0 |
| Cash | 134 | 10 | 383 | 11 | 1 |
| Clinic | 156 | 12 | 280 | 8 | 0 |
| Loan | 4 | 0.5 | 22 | 1 | 0 |
| Bad Debt | 69 | 5 | 153 | 4 | 0 |
| Other | 22 | 2 | 23 | 1 | 0 |
| Combined | 92 | 7 | 395 | 12 | 0 |
| NA | 203 | 16 | 376 | 11 | 1 |
| Total | 1291 | 100 | 3430 | 100 | 2 |

Source: 1) Survey Responses for Attitude, Problems, Delay and Vendor
2) Vital Records Birth File for Maternal Age 10/1/84 through 9/30/85, IBPH

TABLE 5

Distribution of Attitude Toward Prenatal Care Within Maternal Race Groupings

| ATTITUDE | White | | Black | | Oriental | | Other | | NA |
|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number |
| Very Imp | 2271 | 80 | 1507 | 84 | 49 | 74 | 6 | 67 | 1 |
| Imp | 445 | 16 | 199 | 11 | 14 | 21 | 1 | 11 | 1 |
| SI Imp | 51 | 2 | 39 | 2 | 2 | 3 | 2 | 22 | 0 |
| Not Imp | 14 | 0.5 | 11 | 1 | 0 | 0 | 0 | 0 | 0 |
| No Op | 38 | 1 | 27 | 2 | 0 | 0 | 0 | 0 | 0 |
| NA | 32 | 1 | 12 | 1 | 1 | 2 | 0 | 0 | 0 |
| Total | 2851 | 100 | 1795 | 100 | 66 | 100 | 9 | 100 | 2 |

TABLE 6

Distribution of Problems in Accessing Prenatal Care Within Maternal Race Groupings

| PROBLEM | White | | Black | | Oriental | | Other | | Unknown |
|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number |
| None | 1262 | 44 | 1003 | 56 | 43 | 65 | 3 | 33 | 2 |
| Financial | 617 | 22 | 211 | 12 | 12 | 18 | 3 | 33 | 0 |
| Family | 130 | 5 | 83 | 5 | 2 | 3 | 0 | 0 | 0 |
| Title XIX | 91 | 3 | 44 | 2 | 0 | 0 | 0 | 0 | 0 |
| Travel | 96 | 3 | 122 | 7 | 0 | 0 | 1 | 11 | 0 |
| Other | 107 | 4 | 56 | 3 | 5 | 8 | 0 | 0 | 0 |
| NA | 80 | 3 | 57 | 3 | 3 | 5 | 0 | 0 | 0 |
| Combined | 468 | 16 | 219 | 12 | 1 | 2 | 2 | 22 | 0 |
| Total | 2851 | 100 | 1795 | 100 | 66 | 100 | 9 | 100 | 2 |

TABLE 7

Distribution of Vendor Within Maternal Race Groupings

| VENDOR | White | | Black | | Oriental | | Other | | NA |
|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number |
| Insurance | 518 | 18 | 87 | 5 | 10 | 15 | 0 | 0 | 0 |
| HMO | 86 | 3 | 107 | 6 | 3 | 5 | 1 | 11 | 1 |
| Title XIX | 698 | 24 | 879 | 49 | 14 | 21 | 3 | 33 | 1 |
| Cash | 421 | 15 | 75 | 4 | 20 | 30 | 2 | 22 | 0 |
| Clinic | 186 | 7 | 245 | 14 | 5 | 8 | 1 | 11 | 0 |
| Loan | 23 | 1 | 2 | 0.5 | 1 | 2 | 0 | 0 | 0 |
| Bad Debt | 151 | 5 | 68 | 4 | 3 | 5 | 0 | 0 | 0 |
| Other | 37 | 1 | 8 | 0.5 | 0 | 0 | 0 | 0 | 0 |
| Combined | 374 | 13 | 105 | 6 | 8 | 12 | 0 | 0 | 0 |
| NA | 357 | 13 | 219 | 12 | 2 | 3 | 2 | 22 | 0 |
| Total | 2851 | 100 | 1795 | 100 | 66 | 100 | 9 | 100 | 2 |

TABLE 8

Distribution of Delay in Seeking Care Within Maternal Race Groupings

| DELAY | White | | Black | | Oriental | | Other | | NA |
|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number |
| Wk-Mo | 686 | 24 | 344 | 19 | 18 | 27 | 2 | 22 | 1 |
| Five-3M | 965 | 34 | 681 | 38 | 30 | 45 | 2 | 22 | 1 |
| Four-6M | 515 | 18 | 360 | 20 | 13 | 20 | 2 | 22 | 0 |
| Seven-9M | 193 | 7 | 85 | 5 | 2 | 3 | 0 | 0 | 0 |
| NA | 492 | 17 | 321 | 18 | 3 | 5 | 3 | 33 | 0 |
| Total | 2851 | 100 | 1795 | 100 | 66 | 100 | 9 | 100 | 2 |

Source: 1) Survey Responses for Attitude, Problems, Vendor and Delay
2) Vital Records Birth File for Maternal Race 10/1/84 through 9/30/85, IDPH

TABLE 9

Distribution of Attitude Toward Prenatal Care
Within Marital Status Groupings

| ATTITUDE | Married | | Unmarried | | NA |
|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number |
| Very Imp | 1826 | 83 | 2007 | 79 | 1 |
| Imp | 290 | 13 | 370 | 15 | 0 |
| SI Imp | 37 | 2 | 57 | 2 | 0 |
| Not Imp | 6 | 0.5 | 19 | 1 | 0 |
| No Op | 14 | 1 | 15 | 1 | 0 |
| NA | 20 | 1 | 26 | 1 | 0 |
| Total | 2193 | 100 | 2529 | 100 | 1 |

TABLE 10

Distribution of Delay in Seeking Care
Within Marital Status Groupings

| DELAY | Married | | Unmarried | | NA |
|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Numbe |
| WK-Mo | 631 | 29 | 420 | 17 | 0 |
| FiveW-3M | 851 | 39 | 827 | 33 | 1 |
| Four-6M | 336 | 15 | 558 | 22 | 0 |
| Seven-9M | 100 | 5 | 180 | 7 | 0 |
| NA | 275 | 13 | 544 | 22 | 0 |
| Total | 2193 | 100 | 2529 | 100 | 1 |

Table 11

Distribution of Problems in Accessing Prenatal Care
Within Marital Status Groupings

| PROBLEM | Married | | Unmarried | | Unknown |
|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number |
| None | 1148 | 52 | 1164 | 46 | 1 |
| Financial | 465 | 21 | 375 | 15 | 0 |
| Family | 39 | 2 | 159 | 6 | 0 |
| Title XIX | 54 | 2 | 84 | 3 | 0 |
| Travel | 53 | 2 | 166 | 7 | 0 |
| Other | 4 | 80 | 106 | 4 | 0 |
| NA | 63 | 3 | 77 | 3 | 0 |
| Combined | 291 | 13 | 398 | 16 | 0 |
| Total | 2193 | 100 | 2529 | 100 | 1 |

Table 12

Distribution of Vendor Within Marital Status Groupings

| VENDOR | Married | | Unmarried | | NA |
|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Numbe |
| Insurance | 489 | 22 | 126 | 5 | 0 |
| HMO | 88 | 4 | 110 | 4 | 0 |
| Title XIX | 434 | 20 | 1161 | 46 | 1 |
| Cash | 355 | 16 | 163 | 6 | 0 |
| Clinic | 167 | 8 | 269 | 11 | 0 |
| Loan | 19 | 1 | 7 | 0.5 | 0 |
| Bad Debt | 114 | 5 | 108 | 4 | 0 |
| Other | 16 | 1 | 29 | 6 | 0 |
| Combined | 328 | 15 | 159 | 1 | 0 |
| NA | 183 | 8 | 397 | 16 | 0 |
| Total | 2193 | 100 | 2529 | 100 | 1 |

Source: 1) Survey Responses for Attitude, Problems, Delay and Vendor
2) Vital Records Birth File for Marital Status 10/1/84 through 9/30/85, IDPH

TABLE 13

Distribution of Vendor Within Groupings of Problems in Seeking Prenatal Care

| VENDOR | PROBLEM None | | Financial | | Family | | Title XIX | | Travel | | Other | | Combined | | NA |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number |
| Insurance | 439 | 19 | 62 | 6 | 27 | 14 | 1 | 1 | 6 | 3 | 26 | 14 | 44 | 6 | 20 |
| HMO | 139 | 6 | 13 | 2 | 7 | 4 | 2 | 1 | 12 | 5 | 10 | 5 | 12 | 2 | 3 |
| Title XIX | 822 | 35 | 166 | 20 | 65 | 33 | 91 | 66 | 134 | 61 | 40 | 21 | 240 | 35 | 37 |
| Cash | 227 | 10 | 159 | 19 | 28 | 14 | 5 | 4 | 4 | 2 | 18 | 10 | 57 | 8 | 20 |
| Clinic | 243 | 10 | 98 | 12 | 16 | 8 | 6 | 4 | 11 | 5 | 14 | 7 | 40 | 6 | 9 |
| Loan | 8 | 0.5 | 8 | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 0 | 0 | 6 | 1 | 0 |
| Bad Debt | 54 | 2 | 81 | 10 | 6 | 3 | 7 | 5 | 4 | 2 | 8 | 4 | 58 | 8 | 4 |
| Other | 13 | 1 | 12 | 1 | 1 | 1 | 3 | 2 | 0 | 0 | 3 | 2 | 13 | 2 | 0 |
| Combined | 222 | 10 | 110 | 13 | 6 | 3 | 10 | 7 | 8 | 4 | 23 | 12 | 94 | 14 | 14 |
| NA | 146 | 6 | 141 | 17 | 41 | 21 | 12 | 9 | 38 | 17 | 44 | 24 | 125 | 18 | 33 |
| Total | 2321 | 100 | 831 | 100 | 198 | 100 | 138 | 100 | 219 | 100 | 187 | 100 | 689 | 100 | 140 |

TABLE 14

Distribution of Vendor Within Groupings of Length of Wait for Appointment

| VENDOR | Days | | Week-Month | | Two-ThreeM | | FourMPlus | | NA |
|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number |
| Insurance | 179 | 16 | 343 | 15 | 11 | 11 | 1 | 14 | 81 |
| HMO | 46 | 4 | 119 | 5 | 2 | 2 | 0 | 0 | 31 |
| Title XIX | 420 | 39 | 827 | 36 | 28 | 27 | 2 | 29 | 318 |
| Cash | 156 | 14 | 264 | 12 | 15 | 14 | 1 | 14 | 82 |
| Clinic | 77 | 7 | 271 | 12 | 21 | 20 | 2 | 29 | 66 |
| Loan | 5 | 0.5 | 13 | 1 | 2 | 2 | 0 | 0 | 6 |
| Bad Debt | 37 | 3 | 139 | 6 | 6 | 6 | 1 | 14 | 39 |
| Other | 19 | 0.5 | 19 | 1 | 2 | 2 | 0 | 0 | 5 |
| Combined | 144 | 13 | 272 | 12 | 17 | 16 | 0 | 0 | 54 |
| NA | 3 | 2 | 12 | 1 | 0 | 0 | 0 | 0 | 565 |
| Total | 1086 | 100 | 2279 | 100 | 104 | 100 | 7 | 100 | 1247 |

TABLE 15

Distribution of Vendor Within Birthweight Groupings

| VENDOR | Normal BW | | Low BW | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| Insurance | 558 | 13 | 57 | 19 |
| HMO | 189 | 1 | 9 | 3 |
| Title XIX | 1481 | 34 | 114 | 37 |
| Cash | 488 | 12 | 30 | 10 |
| Clinic | 414 | 10 | 23 | 8 |
| Loan | 26 | 1 | 0 | 0 |
| Bad Debt | 212 | 5 | 10 | 2 |
| Other | 42 | 1 | 3 | 1 |
| Combined | 461 | 11 | 26 | 9 |
| NA | 539 | 13 | 41 | 14 |
| Total | 4410 | 100 | 313 | 100 |

Source: 1) Survey Responses for Problems, Wait for Appointment and Vendor.
2) Vital Records Birth File for Birthweight 10/1/84 through 9/30/85, IDPH.

TABLE 16

Distribution of Problems in Accessing Prenatal Care Within Groupings of Length of Delay in Seeking Appointment

| PROBLEM | Week-Month | | Five-Three | | Thirteen-Six | | Twenty-seven-Nine | | NA |
|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number |
| None | 718 | 68 | 964 | 57 | 291 | 33 | 75 | 27 | 265 |
| Financial | 122 | 12 | 275 | 16 | 216 | 24 | 63 | 23 | 164 |
| Family | 13 | 1 | 49 | 3 | 60 | 7 | 20 | 7 | 56 |
| Title XIX | 20 | 2 | 42 | 3 | 35 | 4 | 17 | 6 | 24 |
| Travel | 33 | 3 | 75 | 4 | 55 | 6 | 10 | 4 | 46 |
| Other | 14 | 1 | 41 | 2 | 41 | 5 | 17 | 6 | 73 |
| NA | 27 | 3 | 35 | 2 | 26 | 3 | 3 | 1 | 49 |
| Combined | 104 | 10 | 198 | 12 | 170 | 19 | 75 | 27 | 142 |
| Total | 1051 | 100 | 1679 | 100 | 894 | 100 | 280 | 100 | 819 |

TABLE 17

Distribution of Problems in Accessing Prenatal Care Within Birthweight Groupings

| PROBLEM | Normal BW | | Low BW | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| None | 2149 | 49 | 164 | 53 |
| Financial | 789 | 18 | 51 | 17 |
| Family | 183 | 5 | 15 | 5 |
| Title XIX | 130 | 3 | 8 | 3 |
| Travel | 213 | 5 | 6 | 2 |
| Other | 177 | 5 | 9 | 3 |
| NA | 134 | 4 | 6 | 2 |
| Combined | 635 | 15 | 54 | 18 |
| Total | 4410 | 100 | 313 | 100 |

TABLE 18

Distribution of Problems in Accessing Prenatal Care Within Groupings of Number of Prior Living Children

| PROBLEM | None | | One | | Two or More | | NA |
|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | Number |
| None | 921 | 49 | 675 | 51 | 715 | 48 | 2 |
| Financial | 347 | 18 | 251 | 19 | 242 | 16 | 0 |
| Family | 115 | 6 | 41 | 3 | 42 | 3 | 0 |
| Title XIX | 49 | 3 | 41 | 3 | 48 | 3 | 0 |
| Travel | 57 | 3 | 67 | 5 | 95 | 6 | 0 |
| Other | 85 | 4 | 39 | 3 | 62 | 4 | 0 |
| NA | 49 | 3 | 33 | 2 | 57 | 4 | 1 |
| Combined | 266 | 14 | 179 | 13 | 243 | 16 | 1 |
| Total | 1889 | 100 | 1326 | 100 | 1504 | 100 | 4 |

Source: 1) Survey Responses for Problems and Delay.
2) Vital Records Birth File for Birthweight and Number of Prior Living Children, 10/1/84 through 9/30/85, IDH.

TABLE 19

Distribution of Problems in Accessing Prenatal Care Within Groupings of Mode of Transportation

| PROBLEM | Walked | | Drove | | Passenger | | Public Trans. | | Cab | | Other | | Combined | | NA |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number |
| None | 285 | 60 | 767 | 63 | 347 | 39 | 537 | 53 | 18 | 47 | 2 | 29 | 214 | 47 | 143 |
| Financial | 63 | 14 | 196 | 16 | 171 | 20 | 188 | 19 | 5 | 13 | 1 | 15 | 73 | 16 | 143 |
| Family | 24 | 5 | 34 | 3 | 51 | 6 | 34 | 4 | 1 | 3 | 0 | 0 | 13 | 3 | 42 |
| Title XIX | 15 | 4 | 24 | 2 | 48 | 6 | 29 | 3 | 0 | 0 | 1 | 15 | 8 | 2 | 12 |
| Travel | 17 | 4 | 14 | 2 | 64 | 8 | 62 | 7 | 3 | 8 | 1 | 15 | 21 | 5 | 37 |
| Other | 12 | 3 | 47 | 4 | 23 | 3 | 39 | 4 | 1 | 3 | 0 | 0 | 18 | 4 | 46 |
| NA | 17 | 4 | 32 | 3 | 21 | 3 | 26 | 3 | 1 | 3 | 0 | 0 | 8 | 2 | 35 |
| Combined | 49 | 11 | 115 | 10 | 172 | 20 | 114 | 12 | 10 | 26 | 2 | 29 | 105 | 23 | 122 |
| Total | 482 | 100 | 1229 | 100 | 897 | 100 | 1029 | 100 | 39 | 100 | 7 | 100 | 460 | 100 | 580 |

TABLE 20

Distribution of Problems in Accessing Prenatal Care Within Groupings of Distance Traveled to Care

| PROBLEM | One-Five | | Six-Fifteen | | Sixteen-Thirty | | Thirtyone-Fifty | | Fiftyone-Hundred | | Over Hundred | | NA |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number |
| None | 1022 | 55 | 452 | 49 | 154 | 45 | 50 | 50 | 12 | 58 | 3 | 60 | 620 |
| Financial | 317 | 18 | 171 | 19 | 69 | 20 | 14 | 14 | 1 | 5 | 1 | 20 | 267 |
| Family | 68 | 4 | 31 | 4 | 10 | 3 | 5 | 5 | 1 | 5 | 0 | 0 | 83 |
| Title XIX | 55 | 3 | 29 | 4 | 12 | 4 | 5 | 5 | 0 | 0 | 0 | 0 | 37 |
| Travel | 72 | 4 | 44 | 5 | 17 | 5 | 6 | 6 | 0 | 0 | 0 | 0 | 80 |
| Other | 63 | 4 | 28 | 4 | 16 | 5 | 1 | 1 | 0 | 0 | 0 | 0 | 78 |
| NA | 42 | 3 | 22 | 1 | 9 | 3 | 2 | 2 | 0 | 0 | 0 | 0 | 65 |
| Combined | 225 | 13 | 155 | 17 | 60 | 18 | 19 | 19 | 7 | 34 | 1 | 20 | 222 |
| Total | 1864 | 100 | 932 | 100 | 347 | 100 | 102 | 100 | 21 | 100 | 5 | 100 | 1452 |

Source: Survey Responses for Problems, Mode of Travel and Distance.

APPENDIX H

BREAKOUT OF COMBINED PROBLEMS

| Problem | Number Reporting | % Total Reporting Combined Problems |
|---|---|---|
| Financial Problems | 526 | 76% |
| Family Problems | 204 | 30% |
| Green Card Problems | 160 | 23% |
| Lack of Transportation | 365 | 53% |
| Other Reasons | 220 | 32% |

Source: Survey Responses on Problems

APPENDIX I

CONSUMER CONTACTS REQUIRING DEPARTMENT RESPONSE

| | |
|---|---|
| **Requests for Assistance-Letters** | |
| Birth Certificates | |
| Copies | 6 |
| Changes | 3 |
| Social Security # | 1 |
| Prenatal Ed/Lamaze | 1 |
| 0-3 Services | 1 |
| WIC/WC/SS # | 1 |
| Return Forms Submitted in Error | |
| DPA Application | 1 |
| DPA Card | 1 |
| AP Care for repeat pregnancy-Access | 4 |
| Adult Health Care-Access | 2 |
| WIC-Access | 5 |
| Getting on DPA | 7 |
| DPA Misc. (Off HMO, List of MD's taking DPA, Return BC, Problems with coverage | 5 |
| Purpose of survey before responding | 1 |
| WIC/Birth Certificate | 1 |
| Well Child Care-Access | 11 |
| Advice (Diaper rash, First Aid) | 2 |
| Copy Death Certificate (infant) | 1 |
| WIC/Transportation | 1 |
| Transportation | 1 |
| Financial Aid | 5 |
| Complaints regarding quality of care | 2 |
| **Complaints - Letters** | |
| Infant Deaths | 8 |
| Adoption | 3 |
| Adequate care - Letter #1 | 14 |
| **Complaints - Telephone Calls** | |
| Consumer complaints regarding letter #1 (2/85-3/85) | 9 |

Source: Letters included With Survey Responses or Direct Telephone Calls to the Department.

APPENDIX J

AGREEMENT BETWEEN SURVEY AND BIRTH CERTIFICATE
REGARDING TIMING AND QUANTITY OF PRENATAL CARE

Trimester of Registration for Care

| | Agreement | | Earlier Registration on Certificate | | Later Registration on Certificate | |
|---|---|---|---|---|---|---|
| | # | % | # | % | # | % |
| None | 265 | | | | | |
| 1st Trimester | 381 | 18 | 141 | 7 | 1317 | 75 |
| 2nd Trimester | 300 | 22 | 218 | 16 | 836 | 62 |
| 3rd Trimester | 223 | 48 | 114 | 25 | 125 | 27 |
| Unknown | 57 | | | | | |
| | 1226 | 26 | 473 | 10 | 3024 | 64 |

Number of Prenatal Visits

| | Agreement | | More Visits on Certificate | | Fewer Visits on Certificate | |
|---|---|---|---|---|---|---|
| | # | % | # | % | # | % |
| None | 296 | | 609 | | | |
| 1-6 Visits | 358 | 27 | 267 | 20 | 592 | 44 |
| 7-11 Visits | 51 | 4 | 45 | 4 | 914 | 75 |
| 12+ Visits | 4 | 0.4 | 11 | 1 | 809 | 73 |
| Unknown | 148 | | 619 | | | |
| | 857 | 18 | 1551 | 33 | 2315 | 49 |

Source: 1) Survey Responses on Trimester of Registration for Prenatal Care and Number of Visits Made.
2) Vital Records Birth File for Trimester of Registration for Prenatal Care and Number of Visits Made 10/1/84 through 9/30/85, IDPH.

APPENDIX K

PROJECT BUDGET

| | GPCDD GRANT | MATCH | TOTAL |
|---|---|---|---|
| Personnel | | $2090.00 | $2090.00 |
| Printing Return Envelopes | | 83.00 | 83.00 |
| Postage | | 4510.00 | 4510.00 |
| Paper Supplies | | 1775.00 | 1775.00 |
| Data Processing | | | |
| Computer Time | | 2841.00 | 2841.00 |
| Staff Time | | 2749.00 | 2749.00 |
| Data Entry Staff | $ 6462.50 | | 6462.50 |
| PHN Visits | 35140.00 | | 35140.00 |
| Indirect Costs | 1418.00 | | 1418.00 |
| Totals | $43020.50 | $14048.00 | $57068.50 |

APPENDIX L

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Chairman MILLER. Thank you. Sister Ann.

**STATEMENT OF SISTER ANN PITSENBERGER, O.S.F., EXECUTIVE VICE PRESIDENT, ST. JOHN'S HOSPITAL, SPRINGFIELD, IL**

Sister ANN. I wish to thank the Committee for the opportunity to share with you information relevant to the problem of infant mortality in south central Illinois. My presentation will address both a regional and local perspective. St. John's Hospital is the regional Perinatal Center for South Central Illinois and is also a primary provider of health care services for Sangamon County.

At the spring meeting of the South Central Illinois Perinatal Advisory Committee representatives from the obstetrical departments of the hospitals affiliated with the Springfield Perinatal Center engaged in a planning process which included the identification of precursors to infant mortality within their communities.

Some of these precursors included high malpractice premium rates; increasing unemployment with associated loss of health benefits; inadequate and untimely reimbursement from the Department of Public Aid resulting in physicians' ability to accept "Green Card" patients; teenage pregnancies; inadequate followup of high risk Medicaid or indigent patients.

Researchers agree that the continued decline in infant mortality rates over the past quarter century can be attributed to hospitals providing intensive perinatal medical care. These same experts would also contend that further development of neonatal intensive care capabilities would be fiscally impractical. Interventions provided by the Springfield Regional Perinatal Center which have assisted in the reduction of the regional infant mortality rate include:

Availability of a broad range of technical and subspecialty support services, including an outpatient fetal assessment program which functions as a resource for physicians from throughout the region seeking consultation for potentially high risk maternity patients;

Inpatient services for high risk maternity patients and for critically ill patients;

24-hour consultation capabilities for regional physicians regarding clinical management of the high risk mother and newborn;

Transportation system for movement of high risk perinatal patients to the appropriate level of care;

Provision of continuing education to regional medical, nursing and allied health personnel;

Participation in the review of local perinatal outcomes; and

Followup of patients discharged from the Neonatal Intensive Care Unit.

The Illinois Department of Public Aid's Illinois Competitive Access and Reimbursement Equity Program [ICARE] contracts with hospitals to provide inpatient hospital care to Public Aid recipients. This program is detrimental to tertiary care centers in that it includes ceilings on the number of Medicaid days for which a hospital will be paid, and it does not reimburse in a timely and equitable manner for services rendered.

Recently the malpractice premiums of area obstetricians increased over 100 percent, resulting in annual payments exceeding $90,000. There most likely outcome will be a growing reluctance of physicians choosing to practice obstetrics.

Current Medicaid reimbursement for maternity care is not sufficient to meet the costs incurred by the physician and hospital providing care.

The indigent population is growing. Nationally, Medicaid only covers between 38 to 46 percent of the population near or below the Federal poverty line.

It is our assumption that all persons are entitled to necessary health care and medical treatment as a basic human right. Although some individuals believe the Federal Government must assume ultimate responsibility for guaranteeing that high quality maternity care be available and accessible to all pregnant women, responsibility for primary service delivery should be placed as much as possible at the local level.

As the Select Committee on Children, Youth, and Families reported in 1985, by providing timely prenatal care the number of low birth weight babies can be reduced and thus a reduction in infant mortality.

In addition, for every $1 spent on prenatal care, $3.38 is saved in health care costs related to poor pregnancy outcome as a result of no prenatal care.

Likewise, at the Perinatal Center, the High Risk Maternal Unit has the ability to maintain pregnancies in utero for longer periods of time, which assists in the production of a healthier newborn.

Admission to the High Risk Maternal Unit may reduce the need for admission to the High Risk Neonatal Center.

The average cost of admission to the High Risk Maternal Unit is $3,500, which is less expensive than the average cost of admission to the High Risk Neonatal Center, which is $20,000.

There is no such thing as free care. In the end somebody must pay for the care of the poor. Cuts at the Federal level to Medicaid and block grant programs do trickle down and have stressed local health care delivery systems to the maximum.

Since resources to support programs which work to reduce infant mortality have been reduced, it is necessary to coordinate various program efforts to maximize their impact at the local level. For several years the State Health Department has called for a "widening of the circle of participants and a firmer and more direct commitment to prevention services."

Recently we had the opportunity to engage in a collaborate process addressing prenatal care. A local newspaper published an article which described the problem of early access to prenatal care for the poor here in Springfield. In response to the article Congressman Richard Durbin facilitated a community response to the problem. A number of agencies and individuals, including St. John's Hospital, have been meeting and interventions have been discussed.

As a result of this process St. John's Hospital is currently developing a maternity care program targeted to patients of poverty status who are ineligible for Medicaid funding and to Medicaid patients. The program will utilize a number of community resources:

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Springfield City Health Department, Care Center, WIC Program, Public Aid, private physicians, and the SIU School of Medicine. This program is designed to supplement the current efforts of the local medical and allied health community, not supplant it.

Like many organizations in our community, St. John's Hospital has a mission to serve the indigent. By coordinating the various resources within our community we can maximize services offered and better assist those mothers and children who struggle for their basic right for quality health care.

[Prepared statement of Sister Ann Pitsenberger follows:]

PREPARED STATEMENT OF SISTER ANN PITSENBERGER, O.S.F., EXECUTIVE VICE PRESIDENT, ST. JOHN'S HOSPITAL, SPRINGFIELD, IL

I wish to thank the Committee for the opportunity to share with you information relevant to the problem of Infant Mortality in South Central Illinois. My presentation will address both a regional and local perspective. St. John's Hospital is the regional Perinatal Center for South Central Illinois and is also a primary provider of health care services for Sangamon County.

At the Spring meeting of the South Central Illinois Perinatal Advisory Committee, representatives from the obstetrical departments of the hospitals affiliated with the Springfield Perinatal Center engaged in a planning process which included the identification of precursors to infant mortality within their communities. Precursors included:

. High malpractice premium rates which have resulted in limiting obstetrical services provided by both specialists and family practitioners.

. Increasing unemployment with associated loss of health benefits.

. Inadequate and untimely reimbursement from the Department of Public Aid resulting in physicians'

ability to accept "Green Card" patients.

. Patient transportation problems.

. Client's inadequate knowledge of the importance of prenatal care.

. Irresponsibility of patients in following prescribed care.

. Teenage pregnancy.

. Inadequate follow-up of high risk Medicaid or indigent patients.

. Inadequate marketing of maternity services available to the poor.

. Uncoordinated care by providers and social service agencies; no case management.

Perinatal Center Interventions

Researchers agree that the continued decline in infant mortality rates over the past quarter century can be attributed to hospitals providing intensive perinatal medical care. These same experts would also contend that further development of neonatal intensive care capabilities would be fiscally impractical. Interventions provided by The Springfield Regional Perinatal Center which have assisted in the reduction of the regional infant mortality rate include:

. Availability of a broad range of technical and subspecialty support services, including an outpatient fetal assessment program which functions as a resource for physicians from throughout the region seeking consultation

for potentially high risk maternity patients.

. Inpatient services for high risk maternity patients and for critically ill neonates.

. 24 hour consultation capabilities for regional physicians regarding clinical management of the High Risk mother and newborn.

. Transportation system for movement of high risk perinatal patients to the appropriate level of care.

. Provision of continuing education to regional medical, nursing and allied health personnel.

. Participation in the review of local perinatal outcomes.

. Follow up of patients discharged from the Neonatal Intensive Care Unit.

Regional Barriers

The Illinois Department of Public Aid's Illinois Competitive Access and Reimbursement Equity Program (ICARE) contracts with hospitals to provide inpatient hospital care to public aid recipients. This program is detrimental to tertiary care centers in that it includes ceilings on the number of Medicaid days for which a hospital will be paid and it does not reimburse in a timely and equitable manner for services rendered.

Recently, the malpractice premiums of area obstetricians increased over 100 percent, resulting in annual payments exceeding $90,000. There most likely will be a growing reluctance of physicians choosing to practice

obstetrics.

Current Medicaid reimbursement for maternity care is not sufficient to meet the costs incurred by the physician and hospital providing care.

The indigent population is growing. Nationally, Medicaid only covers between 38 percent to 46 percent of the population near or below the Federal poverty line.

Recommendation:

It is our assumption that all persons are entitled to necessary health care and medical treatment as a basic human right. Although some individuals believe the Federal Government must assume ultimate responsibility for guaranteeing that high quality maternity care be available and accessible to all pregnant women, responsibility for primary service delivery should be placed as much as possible at the local level.

As the Select Committee on Children, Youth and Families reported in 1985, by providing timely prenatal care the number of low birth weight babies can be reduced and thus, a reduction in infant mortality. In addition, for every $1 spent on prenatal care, $3.38 is saved in health care costs related to poor pregnancy outcome as a result of no prenatal care. Likewise, at the Perinatal Center, the High Risk Maternal Unit has the ability to maintain pregnancies in utero for longer periods of time, which assists in the production of a healthier newborn. Admission to the High Risk Maternal Unit may reduce the need for

admission to the High Risk Neonatal Center. The average cost of admission to the High Risk Maternal Unit is $3,500.00, which is less expensive than the average cost of admission to the High Risk Neonatal Center which is $20,000.

There is no such thing as free care; in the end, somebody must pay for the care of the poor. Cuts at the Federal level to Medicaid and Block Grant Programs do trickle down and have stressed local health care delivery systems to the maximum.

Local Perspective

Since resources to support programs which work to reduce infant mortality have been reduced, it is necessary to coordinate various program efforts to maximize their impact at the local level. For several years the State Health Department has called for a "widening of the circle of participants, and a firmer and more direct commitment to prevention services".

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In response to the article, Congressman Richard Durbin facilitated a community response to the problem. A number of agencies and individuals, including St. John's Hospital, have been meeting and interventions have been discussed. As

a result of this process, St. John's Hospital is currently developing a Maternity Care Program targeted to patients of poverty status who are ineligible for Medicaid funding and to Medicaid patients. The program will utilize a number of community resources, Springfield City Health Department, Care Center, WIC Program, Public Aid, private physicians, and the SIU School of Medicine. This program is designed to supplement the current efforts of the local medical and allied health community, not supplant it.

Like many organizations in our community, St. John's Hospital has a mission to serve the indigent. By coordinating the various resources within our community, we can maximize services offered and better assist those mothers and children who struggle for their basic right for quality health care.

Chairman MILLER. Thank you. Ms. Reardon.

## STATEMENT OF JOAN REARDON, COUNSELOR, CARE CENTER OF SPRINGFIELD, INC., SPRINGFIELD, IL

Ms. REARDON. Good morning. I am a counselor in the Care Center of Springfield, and my primary caseload is women who are experiencing stressful pregnancies. These women come from all different age groups and all present with an enormous problem. Some of them already hold their medical card, others are applying for a medical card for the first time and are encountering enormous problems in qualifying for that card. And others are among the working poor. Each of those categories presents a problem in accessing medical care.

For the woman who holds her Public Aid card, or her "green card," her problem seems to emerge as one of locating a physician who will accept that card. The woman who is attempting to get a medical card for the first time very often finds that the necessary paperwork, the documentation, et cetera, is so burdensome that by the time she can complete all of the forms she is well through her pregnancy.

The woman whose husband or who herself is working will often encounter a spend-down amount that makes her participation in medical care impossible. I gave an illustration in my testimony of a woman who came in to see me not too long ago. Her husband earns approximately $175 a week. On this income they support a family of six. She had applied for a medical card and, ladies and gentlemen, her spend-down amount was set at $1,450 for a 3-month period. This clearly made any medical care in the early part of her pregnancy impossible for her. Before Public Aid would step in she had to have out-of-pocket expenses of $1,450 on an income of $175 a week to support a family of six.

In addition to this, she was rated at risk as her prior delivery had resulted in a stillborn infant.

Examining that from the obstetrician's viewpoint also presents an unhappy picture. She has no money to access the system, and any doctor who accepts her as a patient will wait for payment on necessary lab tests, et cetera, until very close to her delivery.

By the way, we did qualify her by arguing that she was disabled, so she went from an AMI category to a category 94 on the Public Aid card. But it took a lot of advocacy to get her that far.

Any lab tests that are done, any initial treatment that is done for a woman entering the medical system early in pregnancy is not going to be covered, because by the time a medical card does backdate 90 days, those tests will never be paid for. They are gone, you know, gone, at that point.

One of our area physicians who has been kind and caring and taken care of many, many women that I have sent in to him, spoke with me last week and told me that his medical malpractice rates are increasing from November 1986, when he paid $37,000, to $96,000 in November 1987. Those rates will be for each doctor in his practice, not for the entire practice. At this time he can look forward to a Public Aid rate that will cover less than one-third of his normal delivery charge, which is $1,500. The economics for the

obstetrician clearly are not there and he, like everybody else, is a small businessman who must earn an income.

We do not like to think of medical care in those terms but that simply is the truth. These doctors have nothing to sell but their skill, and when confronted with a reimbursement level that is less than one-third of what they normally charge, where are they to go?

I think when we look at this question of accessing medical care for the indigent woman, we are tempted to single out quick answers, and in this particular area there are no quick and easy solutions. I thank you.

[Prepared statement of Joan Reardon follows:]

PREPARED STATEMENT OF JOAN REARDON, COUNSELOR, AT THE CARE CENTER, SPRINGFIELD, IL

As a Counselor at the Care Center of Springfield, a small agency that has as its primary clients, women experiencing stressful pregnancies, I am aware of the struggle many of these women face in attempting to access medical care. Many of these women have Medicaid cards. Others are attempting to enter the Public Aid system for the first time in order to secure the necessary funding to receive medical care. Some are among the working poor, employed in poorly paid fields. Each category presents its own particular problem.

Women who have their cards often report an unsuccessful attempt to locate a physician who will accept this particular form of payment. Those attempting to secure a card for the first time often find themselves overwhelmed by the long list of necessary documentation which must be provided in order to be accepted by the system. Those who are working are often accepted for public funding with a spend-down amount that is outside of their ability to meet and virtually proves to be worthless during the initial stages of pregnancy.

In this latter category, I would like to offer a specific example. One of our clients who had applied for Public Aid

Medical assistance was indeed given a "spend-down" card. This spend-down figure was set at $1,457.00 for a three month period. Her husband is employed and earns $175. per week ($162. net) and supports six people with this income. This in effect, denies this woman any assistance with her medical bills until the month of her delivery when her expenses will exceed her spend-down figure.

A physician caring for her would be without any reembursement during the antepartum period. Necessary lab tests, usually ordered in the early stages of pregnancy will not be reembursed as the card will be effective long after the 90 day "back-date" on medical expenses has expired. This woman is in a high risk category, as her last birth had a medical complication which resulted in a still born infant.

I have been employed by this agnecy since June of 1980. In this period of time, I have never been refused medical care for any of our indigent pregnant women. We have enjoyed the support of several dedicated, extremely competent physicians who have cared for the women we have referred to them. They have done this, trusting that our agnecy will pursue all available means of funding but also knowing that the current Medicaid funding levels of $446.50 will not cover their basic office expenses. Much of the early prenatal care provided comes out of these Doctors own pockets. They carry a disproportionate share of the burden of indigent care within

our community, for there are many other qualified physicians who refuse to accept these women under any circumstances. As the number of referrals made by our agnecy increases, the burden on our supporting physicians continues to show a corresponding increase. At the same time this is occuring, medical malpractice insurance rates for obstetricians is escalating at an unprecedented rate. One of our supporting physicians reports an increase of $59,000. (from $37,000. in November 86 to $96,000. in November 87) per Doctor in his practice. Since this cost and the costs of his equipment, staff salaries, operating expenses etc. must come out of his patient charges before he makes his own profit, it does not take a great deal of thought to understand why he must limit the number of Public Aid patients he can care for. His delivery charge for complete antepartum, delivery and postpartum care if $1,500.,one of the more reasonable in our community. Based on current I.D.P.A. rates, he will be paid less than 1/3 of his normal charge.

Due to our ability to access care for pregnant women, we do receive a number of requests from other community agencies to provide this service. I believe we have been successful in maintaining a working relationship with our Doctors because of our proven ability to share the burden of care for these women. Our services are complete in providing close followup which encourages compliance with medical appointments, providing

emotional support through counseling, continually stressing the role of adequate nutrition and providing pre-natal health education. All of these factors impact favorably on giving birth to healthy infants and reduce the number of complications which add a further burden of time and care to the physicians.

In summary, I believe that the problem of providing access to medical care for the poor is a complicated one which does not lend itself to a single, isolated course of action.

Chairman MILLER. Thank you. Carolyn Bodewes.

Ms. BODEWES. I am available for questions on my written testimony. Thank you.

[Prepared statement of Carolyn Bodewes follows:]

PREPARED STATEMENT OF CAROLYN BODEWES, PROJECT DIRECTOR, CARE CENTER OF SPRINGFIELD, INC., SPRINGFIELD, IL

The Care Center of Springfield, incorporated in 1979, is a non-profit agency providing pregnancy crisis intervention for teens, unmarried women and married low income women.

Services include pregnancy testing, individual and family counseling, Lamaze and prenatal classes, nutrition education, home visits, physician and agency referrals, prenatal vitamins, and limited public aid level reimbursement to physicians for prenatal care and delivery.

Non-medical services include pregnancy prevention outreach to schools, legal assistance, emergency funds for food, clothing, medicine, transportation, maternity and infant clothing and furniture.

The Care Center's FY88 budget consists of approximately 40% from state grants, 25% from private funds and over 35% from in-kind services (the single most provider is St. Johns Hospital in Springfield).

In FY86, 524 cases were opened resulting in 212 assisted births. In FY87, 550 cases were opened resulting in 243 assisted births. Of these 243 mothers, 63 received public aid assistance prior to being served by the Care Center with an additional 81 referred to Public Aid for assistance after contact with the Care Center. The remaining deliveries were paid for by PTS Grants,

insurance or Care Center funds.

The Care Center currently has agreements with four Physician Groups who accept Care Center clients at the current Public Aid rate of $446.50 for prenatal care and delivery of an uncomplicated vaginal delivery. Because of these agreements the Care Center has reached 100% client referral for medical services. The Care Center assists the client in pursuing funds to cover delivery costs.

The physicians supporting the program endorse the philosophy which is built upon counseling and specific health education for the individual needs of each client.

The access to Prenatal Care is far beyond the responsibility of the private physician. To suggest that even the most dedicated physician who is already accepting the patient at a financial loss is capable of giving the needed prenatal care is not to view the problem accurately.

Pregnancy is rarely an isolated problem with Care Center clients. These clients are for the most part unmarried, poor and from severly dysfunctional families without life goals or motivation. Their social and emotional needs are staggering. They do not understand the need for medical care and often do not comply with medical appointments.

By providing pregnancy counseling, prenatal, Lamaze and nutrition education, tracking physician visits,(particularly post-partum visits) and generally caring for them, the chain

of repeat pregnancies can be broken.

The Care Center has consistantly demonstrated that if good medical care is given along with meeting a client's social and emotional needs, the probability of personal trauma and tragedy is avoided.

The growth of this program and the broad community support speaks to it's success in accessing good prenatal care. The Care Center's state funding is through a decreasing grant. The problem of adequate funds to continue our program is growing to crisis proportions.

Chairman MILLER. Oh. OK. And Dr. Fraed.

## STATEMENT OF CYNTHIA FRAED, M.D., OBSTETRICIAN AND GYNECOLOGIST, HARRISBURG, IL

Dr. FRAED. I would like to thank you for the opportunity to come and testify before this committee.

I am a board-certified obstetrician and gynecologist working in southern Illinois, one of the areas hardest hit that we have heard all about from the people who have already testified. The stories that you heard from the two young women, that were read, were more than typical. There are other people out there who do not have whatever means to participate in their own care. Unlike the two women who mentioned that they understand that prenatal care is important, there are many people out there who do not.

There has certainly been any number of ancillary committees and help formed. The bottom line on all of this is that they cannot get prenatal care without doctors.

In Illinois, my own personal story, in 1983 my malpractice premium was $11,000 a year. At that time I hired an LPN from the OB Department, I sent her to RN school, I trained her and sent her off for additional training in Denver for family planning, brought her back, taught her how to do pelvic exams and how to do prenatal care so that she could care for Public Aid patients in my office while I was present. I saw these patients on an initial visit to screen them for problems and I was present for whatever problems Linda found when she examined them. I then went and delivered them and had them come back for postpartum care.

I did everything within my power to make that a situation where I could break even. And gentlemen, after 2½ years I not only could not break even, I was faced with not only financial but emotional bankruptcy because of the drain that that placed on me as an individual.

At that point I shortly after that not only stopped delivering Public Aid patients but I also stopped delivering obstetric patients after 10 years of practice.

After a 9-month hiatus and just doing gynecology for a while, for any number of personal reasons I have gone back to delivery and I have promised the hospital in Harrisburg that I will deliver for the next 2 years. Six months of that is already past.

Under the malpractice climate and under the economic climate in my area I cannot provide Public Aid services. I simply cannot afford to pay out of my pocket money that I do not have to provide care for people that desperately need it. I am one person. I cannot provide the entire solution to this problem.

I do not know where the answers are. I suspect that they are in several directions. First of all, I think we have to find some solutions to the malpractice situation. I live approximately an hour and a half from Evansville, IN. A year ago the malpractice premium for obstetrics in my area was $64,000. An hour and a half away the premium was $12,000, in Indiana. The private patients could go across the river and have a Level 2 nursery and a physician who does not charge you quite as much but who is getting a whole lot

more, as well as having a decreased risk of malpractice because of the system in Indiana.

Illinois is not supporting its doctors. I have talked to many people who not only have quit obstetrics, changed fields and left the state and are leaving medicine. I have already done that once for a brief time. If the situation is not remedied in the next 2 years I very likely will leave the field of medicine completely.

The next thing is the reimbursement for Public Aid. After paying the nurse that I hired to do the Public Aid prenatal care and training her, and paid her salary and the salary of the secretary—it took her possibly between 30 and 60 percent of her time in the office to bill Public Aid repeatedly for the same care, only to have it come back and say, this was denied, or this has already been allocated. Those two salaries more than covered what I was reimbursed for the entire care for 70 Public Aid patients in 1985. Out of 210 deliveries a third of them were Public Aid. I cannot survive on that and I certainly do not have the energy to be up and deliver all those patients and not at least break even.

I had a staff to support; I had office overhead. That may sound terribly economic, and it is, but it also happens to be a very real reason why we are in this situation today.

I would appeal to you gentlemen, find some solutions, not only in tort reform but in Medicare reimbursement—or Medicaid reimbursement; excuse me.

People out there need care. I would not mind giving them care but I cannot afford to do it completely gratis with no means of support.

With that, I will be open to any questions, and thank you for your attention.

[Prepared statement of Cynthia Fraed, M.D., follows:]

PREPARED STATEMENT OF CYNTHIA FRAED, M.D., BOARD-CERTIFIED OBSTETRICIAN AND GYNECOLOGIST, HARRISBURG, IL

My name is Cynthia Fraed. I am a board-certified obstetrician and gynecologist from Harrisburg, Illinois. I have been in practice for 10 years. Today, I will spend my allotted time describing the desperate state of affairs for pregnant women -- especially the indigent -- who are seeking obstetrical care in southern Illinois.

I characterize the situation as "desperate," and it is nothing less than that. A recent study of seven southern Illinois counties failed to turn up even one obstetrician in the area. These counties, with a population of over 76,000, adjoin my practice locale. Thus, I experience first hand the trauma of prospective mothers who are searching for medical care -- and are unable to find it without travelling to Missouri or Indiana.

Unfortunately, I cannot help them. For two and one half years I operated a clinic for public aid patients. But I was forced to abandon it two years ago; and shortly afterwards made my decision to give up delivering babies. I have since returned to obstetrical work on a limited basis, but economic realities

have prevented me from returning to care of indigent patients.

The reason is that the Medicaid system in Illinois makes it impossible to do so and economically survive. I found during my years of treating mothers-to-be on public aid that the system posed many dilemmas for doctors and their patients. I'll mention three:

-- First, the economic reimbursement actually provides a disincentive to treat Medicaid patients. For prenatal, delivery and postnatal care the current reimbursement rate is only $446. For a delivery only, the reimbursement rate is currently $304.30. This is not even enough to cover office overhead and massive Medicaid paperwork, let alone medical malpractice premium costs. I now charge $1,000 per delivery for the nine-month care of mother and fetus. This is only a little more than the "break even" price for my services. To deliver Medicaid babies and provide their mothers prenatal care, I would be essentially bankrupting myself and my medical practice.

-- Second is that until recently -- long after I reluctantly gave up treatment of Medicaid patients -- the Medicaid reimbursement

for nine-month prenatal care included any other medical care the prospective mother received while pregnant. For instance, if she had a cold and went to her family physician, that doctor was paid out of the allotted Medicaid reimbursement for prenatal care and delivery.

I understand that this has, very recently, been rectified. But it poses a dilemma which still holds true for physicians treating Medicaid patients. That dilemma is: the more complicated the Medicaid patient's medical history and condition, the less the obstetrician is compensated. And, need I remind you that all public aid patients, including prospective mothers, have more often than not, had little in the way of regular, preventive medical care? And they more likely appear later in their pregnancies for physician treatment -- often only after nutritional deficiencies or other serious complications have developed.

In fact, this scenario causes one major problem confronting this Select Committee: high infant mortality rates, or at the very least, extensive and costly medical care for premature and/or malnourished infants. In the long term, I believe we

could save dollars by raising Medicaid reimbursements for physicians, thus providing easy and early access to obstetrical care and producing, as a consequence, healthier babies.

-- The third dilemma I wish to address today is the impact of the medical malpractice climate on obstetricians and patients. These days, everyone -- whether or not they've had proper, or even any prenatal care -- expects a perfect baby. And medical malpractice courts are often agreeing, without regard to actual negligence. An injured or retarded child presents a sad, sympathetic scenario in courtrooms across Illinois and our country. Perhaps there should be some way to help parents provide for the expense of long term care which such children will need. But medical malpractice compensation was not designed or funded to provide for such "no-fault" compensation. And we are all paying the price when juries hand out large awards based on sympathy rather than negligence.

Part of the reason there are few colleagues left to deliver children in southern Illinois is that many have moved across the borders to Indiana, where malpractice premiums are less than a quarter of ours. That state has strong tort reform

laws, including a cap on court awards at $500,000.

These days, our malpractice bills can approach $100,000 in some areas of Illinois. My own is currently $21,000 semiannually. But I recently switched insurance companies after St. Paul Fire and Marine Insurance Companies boosted my premium level to $45,000 semiannually, with the promise that the premium would rise every six months for the next five years.

Illinois doctors have been working to better the climate here through tort reform. It is an essential piece of the total remedy needed to assure health care access for indigent mothers-to-be.

Finally, a word on why, in the face of all this, I decided to re-enter obstetrics. I love delivering babies. It was what I trained to do. It used to be generally a "happy" specialty of medicine. But that's still not enough to allow me to take on indigent Medicaid patients. It's a losing proposition. I don't like turning them down; I loathe it, in fact. But if I don't I won't be able to survive to treat the other patients who need me to deliver their children.

This concludes my statement. I would be pleased to answer any questions which committee members might have at this time.

Chairman MILLER. Thank you. I have an announcement, that Dr. Fesco is to call his office immediately, and there is somebody in the back of the room that will show you the way to a phone here. Is Dr. Fesco in the room?

Dr. FESCO. Yes.

Chairman MILLER. Thank you very much for your testimony. It seems to me that quite often we talk about our system of health care in this country as being the finest in the world, and I think it is, but clearly what you are describing is an obvious and serious flaw in access to that system of care, especially for populations of low income individuals in this setting in this rural area.

If I can take a second to explore some of this. Dr. Turnock, you talked about the expansion of some of these eligibilities. Is this because the State is more restrictive than the Federal law in some instances?

Dr. TURNOCK. At the time those eligibilities were expanded they allowed the Department to pick up on some of the Federal options that were provided for under the various Omnibus Budget Reconciliation Acts of the past few years.

Chairman MILLER. Now, has that been done? Is that completed? Have you picked up all of those options in Illinois?

Dr. TURNOCK. No, they are not all picked up yet. The two that occurred last year with the expanded eligibility for Medicaid to all pregnant women is one that will be implemented. The level of implementation, meaning—the level of current need or the Federal poverty level, has not yet been decided upon. That is an issue that the Department of Public Aid is bringing to the Governor's Office and to the General Assembly as a budget issue because of the cost implications.

They are also evaluating the desirability of the presumptive eligibility option that was provided for in last year's Federal legislation.

Chairman MILLER. What is the estimated price tag on that?

Dr. TURNOCK. On presumptive eligibility? I am not sure. The estimated price tag on the other, the expansion of the Medicaid eligibility, was anywhere from $3 to, I think, almost $30 million depending upon the income level selected.

Chairman MILLER. Do you have any idea what that income level would be, what is anticipated in terms of selection?

Dr. TURNOCK. I know that the Department of Public Aid would like to have the highest level possible, the Federal poverty level, and that would cost $30 million, but the possibility of that has to be discussed within the context of next year's budget and with the General Assembly as well.

Chairman MILLER. Sister Ann, this program that you are describing, you are talking about this facility apparently taking pregnant women who bring no resources, not a Medicaid card, not a State card, no resources at all. Is that correct?

Sister ANN. That is right, yes.

Chairman MILLER. How are you going to absorb that?

Sister ANN. Well, I think, as I mentioned, someone has to pay for it, and so it has to be given to the payors to subsidize.

Chairman MILLER. Will any of these State initiatives provide any resources for those individuals to this program?

Sister ANN. Hopefully, yes.

Chairman MILLER. But you do not know that yet?

Sister ANN. No. We do—we are able to get some perinatal money, which would also help in this program, at the present time.

Chairman MILLER. Dr. Fraed, what is the cost? Everybody has testified, and we have heard from other areas that the Medicaid reimbursement is far below the cost of delivery of those services. What do you estimate the cost to be for prenatal care and delivery?

Dr. FRAED. Right now I am charging $1,000 to my private patients.

Chairman MILLER. And that would entitle them to what kind of care—how many visits or consultations with you?

Dr. FRAED. It entitles them to as many pregnancy-related visits as are necessary for their prenatal care, whether that is once a month at the beginning with closer visits later on or whether that happens to be once every 2 or 3 days, as it really is in some cases. And that is the same type. That is the way I have always set that up, is that it is a flat fee, and it covers as many visits as are necessary.

In order to deliver Public Aid patients the reimbursement right now is about $450. When I was trying to see Public Aid patients I set certain limits. They had to have their card in hand on the first visit because otherwise the entire thing was free.

Secondly, they could not have any spend-down——

Chairman MILLER. Why was the entire thing free?

Dr. FRAED. Because there was better than a 50-percent chance that the card would never be assigned. So eventually I'd end up footing one more thing, except for the lab work which my hospital took care of.

Chairman MILLER. And your second criterion Dr. Fraed?

Dr. FRAED. The second criterion was that they had to have the card in their own name. If it happened to be in their parents' name, if they were a young woman, again, by the time you filed, you did not get any money.

The third criterion was that they could not have any spend-down, as I mentioned before. If they came in with a spend-down, then, again, that meant that the patient had to pay whatever that spend-down was up front before I could kick in and put the card in. In the case that was mentioned she had a spend-down of $1,400. At that time my prenatal care cost, or fee, was $800. Medical care was covering—Medicaid was covering approximately $390-something at that time.

By the time the patient had $1,500 worth of paid bills out of her pocket, if I turned around and submitted the medical card they made me refund all but the $390 that they would pay, and then they would only pay what was beyond what the patient would not pay, and the bottom line was it did not pay anything. The patient could not afford to pay the spend-down, which was why she had the green card in the first place. In the second place she could not afford me and I could not afford to do that again, for free.

Patients that came in with no insurance again were frequently what we call private pay/no pay. And I knew up front that what I was doing was care for free. We cannot continue to do that in our

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business. You cannot continue to do that and pay your staff. Those are the realities in the situation.

I would love to see, along with the rest of this, some money put into advertising the condoms. Some of these girls do not have any idea what birth control is about. I have seen people on medical cards come in for their third and fourth pregnancy, some of them for caesarian sections.

By the way, if I did a caesarian section, the Public Aid Department would pay me an additional $75 for the care, and that certainly is a very low fee for major surgery. At this point I am charging $500 for a caesarian section above and beyond my prenatal fee.

If I happen to do a tubal and tie their tubes at the same time I did a caesarian section, Public Aid told me that that was free and there was not any fee for it at all.

So that, if I did prenatal care and caesarian section and a tubal ligation, I got a maximum benefit payment of approximately $460. And that was if at the time the patient had not been seen by somebody else during the pregnancy. This has apparently been rectified at this time but when I was doing this, if the patient went to the emergency room for a cold, saw another doctor for anything, or if I had to refer her for consultation because of a complication of the pregnancy, that was deducted from the maximum allowable fee for that pregnancy, so by the time——

I can think of one patient that had acute polyhydramnios, which meant that she had way too much amniotic fluid, to the point where it put her at risk for delivering prematurely. I sent her to the Level Three Center designated for my area, which happens to be St. Mary's Health Center in St. Louis, had her seen by the man out there who was their perinatologist at the time.

They did an anomaly screen ultrasound to make sure there was not some terrible reason why she had this. They could not find any reason. They did other tests and could find nothing wrong except that this baby had a lot of fluid around it, which leads to a host of possible reasons for this. The care that we decided upon was for her to come back to central Illinois and to have me drain off the fluid at periodic intervals to try and keep her from going into premature labor because of the excess pressure on the uterus.

I spent three nights up all night taking off amniotic fluid at the rate of 50 cc. per 10 or 15 minutes to make sure she did not go into premature labor.

She finally went into premature labor and was transferred by helicopter to St. Louis and delivered there. Since I did not deliver this patient I was not permitted to submit any fee for this care.

Chairman MILLER. That leaves me scratching my head. Ms. Reardon, you are nodding your head a lot. Is this typical?

Ms. REARDON. These are old stories; yes.

Chairman MILLER. This is the way it is run?

Ms. REARDON. This is the way it happens. We have been working with women who are pregnant and poor for about 7 years now. In that period of time I can really tell you that the generosity of a handful of physicians in this area have kept us alive and kept us able to do this. Why these doctors do not just hide under their desks when I call, I do not know. Because when they take one of

my patients, they know that they are going to provide a good bit of that care out of their own pocket. All I can do is say, thank you.

I do not have tremendous funds to reimburse them, I cannot pay for the lab tests that are necessary, and by the time Public Aid backdates, if the woman even qualifies to their generosity and their time that we have anyone seeing our patients at this time.

We do see a substantial number of women who are not teenagers, who are among the working poor, and they are not really covered by a lot of programs. The Care Center is their main place to go for access into the system. The teenager living at home will quite often be covered under a parent's insurance policy. The woman who is 23 and may be working part-time and does not have health insurance is in a much different category, and she is quite often the most desperate.

Chairman MILLER. Thank you. Mr. Durbin.

Mr. DURBIN. Thank you, Mr. Chairman. I would like to say at the outset, some people may wonder how this hearing came about. Frankly, it came about because of the willingness of George Miller to travel here, and of the Select Committee, to do the hard work to put it together. But if you predate it even further, it came about because as I walked out of the grocery store in Springfield a few months ago and picked up a copy of Illinois Times newspaper. I read a feature by Don Sevener, who is in the audience, about being pregnant and poor in Springfield and it opened my eyes. There were liberal citations and quotes in that article from some of the participants in this panel, Joan Reardon in particular, and Joe McHugh of Planned Parenthood, about the problem in our community.

Springfield as a community is rich with medical resources. And I think, Dr. Fraed, you would gladly have these hospitals at your ready disposal and all of the resources that we have. But clearly there is a problem.

Let me try to note a couple of things here that have occurred since that first meeting of community leaders on this. Let me say at the outset that we had cooperation with virtually everyone involved in this community. But I want to make particular note of Sister Ann Pitsenberger of St. John's Hospital.

For those who do not know, people show up at the door here at St. John's in labor. They are brought in for delivery regardless of what their resources are. If a child needs neonatal care it is brought in for help regardless of the resources.

Sister Ann and I had several conversations with Al Laabs and decided there was a piece missing here. And the piece, of course, was prenatal care to avoid complications.

I think, Sister, your testimony pointed to the need and your willingness to make a commitment to move forward in this area, and I salute you for that.

Let me ask you, Sister, you said something in your testimony about the Neonatal Care Center upstairs, that expanding this was, I think, fiscally impractical. Can you translate that?

Sister ANN. Well, I think, as has been already said here, you do have costs, expenses that have to be paid for. And funding just is not there always, for this kind of patient. So to expand its program further would be detrimental, costwise.

Mr. DURBIN. More specifically, what do you lose on Medicaid reimbursement for the children upstairs in the Neonatal Care Center?

Sister ANN. We are paid a per diem, and right off the top of my head I am not sure what that per diem is, but it does not always add up to the care that is given to the patient, or the length of stay that is there.

Mr. DURBIN. So the Government reimbursement is not paying for the expenses of the Neonatal Care operation?

Sister ANN. That is right.

Mr. DURBIN. Joan Reardon, can I ask you how many doctors are participating in the Springfield area, and how many obstetricians are taking your referrals on Medicaid and uninsured patients?

Ms. REARDON. Oh, give me a brief moment.

Mr. DURBIN. I think we have about 22 obstetricians in Springfield, if I am not mistaken.

Ms. REARDON. Currently I rely very heavily on three offices that would total seven physicians. No one is unkind to me. When I call I get very interesting responses, though, from many of the other offices. "Gee, we've got a quota." And, "You know, you are calling with a delivery seven months in advance and we are already filled up with our quota of Public Aid," which in effect is saying no.

Another thing that I hear quite often is, "We do have an appointment available and that will be in January." That is saying no, too. There are many different ways of saying, no.

The physicians who support us, who have given so generously of themselves, see our referrals within a week to 10 days. And as I said, I really do not know why because every time the phone rings they know I am costing them money; but they continue to do that.

Mr. DURBIN. It strikes me as we get into this that there are several stages that we have to address in the problem. The first is public information, the knowledge of the pregnant mother that she needs prenatal care as early as possible. What is being done in our community or in the State? Perhaps Dr. Turnock can address this to get that information?

Dr. TURNOCK. I think that is a very important point. Let me just preface it by saying that a year or two back we looked at all of the women who received very late or no prenatal care and attempted to contact them to find out why they did not, and to help us determine what some of the reasons were, the barriers to access to care for them.

I think the most surprising finding from that was that among all those women who responded, half of them said they did not have any problem, and the other half had a variety of problems that related to such things as financial ability, transportation, family problems, doctors who would not take green cards, and things of that nature. But I think it paints the picture in at least two different lights here, one of which is that we have to get the word out to change behaviors and motivation, and to that extent the State Health Department and many of the regional perinatal networks, many of the "Families with a Future" community networks, have been involved in a large promotion, and marketing campaign. It includes a media campaign as well as local promotion and marketing

efforts to get the word out, in terms of outreaching at least through those particular means.

I think that is a key issue that, whatever we do with the financial access, we still have to get into people's minds to influence them so that they will be more aware of the need for and benefit of the kinds of services that are offered.

Mr. DURBIN. Doctor, let us stay with that just for a second. I noted in your testimony about your disappointment with the increasing infant mortality rate in the State of Illinois, and the plateauing of the rate, which you referred to earlier. Behind those statistics of 11 per thousand you will find some interesting subgroups. Particularly among black Illinoians you will find that the infant mortality rate is twice what it is among whites. It suggests to me that we do have serious problems downstate in rural areas for the reasons mentioned. And I am sure we will hear this afternoon that in the City of Chicago there are substantially different problems.

You cannot turn on a radio or TV in the District of Columbia, where we work several days a week, without hearing a public service spot. It is entitled, "Beautiful babies right from the start."

The District of Columbia has a serious infant mortality problem. They are aggressively going after it with movie and television stars in an effort to get the message across to young women, perhaps teenage mothers, to get in to a doctor quickly for their prenatal care.

Illinois has the worst infant mortality rate, according to 1984 statistics, of any northern state in our country. What are we doing in an aggressive fashion in Illinois, like the District of Columbia and other areas, to bring out this educational point, to convince people that they have got to come forward and see a doctor as quickly as possible?

Dr. TURNOCK. We have extensive media campaigns both with Parents Too Soon, the teen pregnancy program, and with Families With a Future, that includes public service announcements on the radio and television, and reinforced by the involvement of the local agencies with the local media. It has involved bus cards and other kinds of promotional events, including within Parents Too Soon, anyway, a national song-writing contest, and a variety of others. But I think we realize that that is a need. But there are heavy involvements in those areas being developed and planned for the future.

Mr. DURBIN. Is our present level of commitment to public education information adequate in Illinois?

Dr. TURNOCK. I believe it is. I think that is an emerging issue that we have taken quite seriously. We believe that is one of the solutions to this problem, that whatever changes we make in the health care delivery system will not be enough, that we have to influence the consumers as well as the providers of services and attempt to improve that match or that link between them that we have been unable to improve upon in the past.

Mr. DURBIN. Thank you. Dr. Fraed, I would like to ask you, you made reference to cesarean sections in your practice. Have you seen any trends in recent years in terms of the number of cesarean sections that are being used?

Dr. FRAED. Yes, I have. In my training I was lucky enough to do a significant number of vaginal breech deliveries. With the litigation climate today there is no way that I would do a breech vaginal, period. Those babies get sections because if something goes wrong the first thing the attorney says to me, "Well, why didn't you do a cesarean section, Doctor?" And I will not have any answer.

I would like to make one other comment——

Mr. DURBIN. Before you start that, could I ask you as a followup, what percentage of your deliveries are C-sections?

Dr. FRAED. Around 18 percent.

Mr. DURBIN. I am told that the statistic is much higher nationally, and that the current rate represents a dramatic increase over what it was several years ago. Would you disagree or agree with that?

Dr. FRAED. No, in some places in various populations the cesarean section rate is reaching as much as or more than 25 percent. I deal with as much of a low risk population as I can. And that makes a difference, where I am.

Mr. DURBIN. And you think this is defensive medicine that primarily pushes obstetricians toward C-sections?

Dr. FRAED. I believe that that plays a big part in it. It certainly has played a part in not only how I do cesarean sections and when I choose to do them, but it also has played a big part in what I do as far as routine prenatal care. Since I have gone back to delivering I have now started doing two routine sonograms which insurance does not pay for, usually. I have added doing screening blood sugars, screening urinalyses, additional tests that I never did before unless I thought that they were indicated either by history or by clinical evidence that I needed to do them. I do these tests now to protect me.

Mr. DURBIN. So the sonograms, in particular—the two sonograms that I think are more or less commonplace in pregnancy now—you feel motivated at least to some extent by this whole malpractice climate?

Dr. FRAED. Totally.

Mr. DURBIN. And what is the cost of a sonogram?

Dr. FRAED. I think that it is approximately $90 apiece, at this point.

Mr. DURBIN. I interrupted you. I am sorry.

Dr. FRAED. The other thing that I wanted to point out is that this is not because of a problem just for patients that cannot afford care because they do not have money. It is becoming a problem because physicians are no longer available. They are leaving this State at an alarming rate.

I stopped for 9 months. At the time that I stopped there were two obstetrician-gynecologists and three family practitioners in my town delivering babies and we were delivering approximately 600 babies a year. At this time we are 30 miles from the nearest other hospital that is doing any deliveries at all. We are approximately an hour away from any Level 2 perinatal center for high risk patients of any kind. At this time one of the other obstetricians left my town and went to Evansville because of the $52,000 difference in his premium and the decreased risk of litigation. We have since

gotten another physician in and I honestly do not feel he is going to stay, and we are going to be back in the same situation and looking for somebody else.

All three family practitioners will have stopped delivering babies by April of this year. Across the entire southern portion of Illinois the same situation is happening. People are limiting their practices, decreasing their number of deliveries because they can get a lower insurance premium.

I recently changed companies. There was a new company that opened in Illinois that literally saved my bacon. It was a matter of looking at becoming bankrupt within the next 2 years, because I got a premium notice from St. Paul for $45,000 for 6 months, with the assurance that it would go up in the fall in 6 months. I cannot work hard enough to generate that kind of money in an economically depressed area, even from patients that are not Public Aid, let alone taking the generosity to offer that care to patients that cannot even afford to help me break even.

Mr. DURBIN. Thank you, Mr. Chairman.

Chairman MILLER. Mr. Hastert.

Mr. HASTERT. Thank you, Mr. Chairman. Dr. Turnock, you stated that the record of Illinois in 1986 is that we actually got a slight increase in deaths per thousand. Yet you also testified that we have had, in the last 30 months, spent over $132 million in the area of infant mortality reduction programs. When do you see that we will start to see some results from the change?

Dr. TURNOCK. Well, most of the programs that I described began in 1986, so I think it would be very presumptive to believe that they would have any impact upon pregnancy, especially infant deaths that would have occurred in that year, and that we would expect to see some benefits occurring in 1987, 1988, and 1989, clearly, in a year or two down the road, after these community networks are up and running and well linked to the medical care and regionalized perinatal systems. So I would suspect that is when we will see their impact, and until then we are likely to remain on this plateau.

Mr. HASTERT. Yes. Across Illinois there are people who are fortunate enough to live in areas where there are a large number of resources. You take Springfield, where we have a state medical school and then a center, and around that we have a large number of physicians some of whom open their services up, according to the testimony here, and the dedication of people in hospitals like St. John's here, and Sister Pitsenberger, for instance.

There are a lot, across the State of Illinois, of locally funded projects that have been positive. Have there been positive impacts from these types of programs yet?

Dr. TURNOCK. I think probably all of the panelists involved in the programs could comment. I think very clearly there have been positive impacts and benefits noted with a lot of the projects that were funded under the prenatal care program or under the problem pregnancy program or under the Parents Too Soon program. Certainly the regionalized perinatal care program has made a dramatic impact upon perinatal outcomes over time. So I think there is lots of information about one or a combination of various projects that have made a significant benefit.

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But all of these programs are moving against the tide that seems to be turning against us in terms of the number of low income or indigent women, the increasing malpractice insurance rates, the lack of availability of primary care providers in many parts of our State.

Mr. HASTERT. Well, Doctor, if it is we who are involved in this, the theme comes out very plainly that there is a problem. There is a problem in Illinois and it is a problem that we have that is somewhat unique among the northern industrial States, that first of all, it is a problem of access. It looks like we are literally chasing you people out of the profession of providing the type of services that we need.

Secondly, there is a problem on getting enough money to those people so that care can be provided. And a theme that I have heard over and over here, so far today, is the malpractice insurance premium problem in Illinois. What impact do you see that that plays?

Dr. TURNOCK. Well, it plays a significant impact, and for that reason our agency together with the State medical society is doing and has almost completed a survey of family practitioners and obstetricians across the State to determine from them exactly what is the impact of these forces? How many of them have reduced the number of public aid recipients? How many have closed their doors to Public Aid recipients? How many family practitioners have dropped obstetrics as a practice? How many obstetricians have dropped obstetrics? What are the prime reasons that they see from a practice point of view? I think that will help us quantify a little bit better from the provider end of it, what the problems are with malpractice and low reimbursement rates for public programs, and to get some sense from them what might be appropriate solutions that would meet at least some of their needs.

Mr. HASTERT. Let me ask a followup question to that then. Let's get down to brass tacks. Why are we different in Illinois, as opposed to our neighbors in Missouri and Indiana? What is the problem? What is the difference?

Dr. TURNOCK. I do not believe we are different. I do not believe that we are different than most other states. I think we have a slightly higher rate but when you look at Michigan or Ohio or Pennsylvania or New Jersey—even Missouri had their rate go up last year as well—I think we are all in the same set of circumstances.

Our rate began much higher. We have had a higher rate than the national figure since 1965, so it is not a new problem for Illinois, and in fact much of that gap has been closed over the course of the last half dozen years.

The problem is low birth weight, and very low birth weight, and the wide variety of nonmedical factors that are associated with that that have to do with income and poverty and access to care and educational level and family structure, and our ability to deal through the day care and the transportation and the other kinds of service needed. That is the prime reason that I would see why we have continuing high rates of low birth weight and especially very low birth weight. And since those births contribute so heavily to our infant mortality and our fetal mortality and our perinatal mortality rates, we are going to have a problem until we deal with the

basic social issues that impact upon health status in a family and in a community.

Mr. DURBIN. Dr. Fraed, you gave some very, very interesting testimony, saying that basically you cannot afford to be a provider for this service. My heart goes out to you and the families that you serve. But how do you see it? What needs to be done in this State? Let us lay it out on the table.

Dr. FRAED. OK. I think you need some severe malpractice reform, first of all. We need a cap in this State. We have been told by the legislature that we are not going to get it. The differences between what happens here and in Indiana are significant. In Indiana there is a review panel to weed out frivolous cases. We do not have that in Illinois. It has been declared unconstitutional. In Indiana they have a cap of $250,000 economic loss—or not economic—$250,000 out of pocket from the insurance company. The physicians do not have to pay more than that. There is apparently a state pool, but I am not quite sure how that works, but there is a state pool that helps some with that.

Part of the biggest problem in this whole situation is that we have had such a good medical system in this country and the physicians are probably as much to blame as any other system, in letting people believe that we can fix anything. People expect a perfect child. A lot of their mortality and their immortality is tied up in that baby. And they are in a position where if something happens to that baby, they were powerless to do anything about it, and somebody has to be at fault to assuage the guilt that comes out of that situation.

Unfortunately I am usually it. The statistics that I heard before I quit were that obstetricians in this State were being sued at the rate of one to three times per year per doctor in Illinois. It is very frightening to try to practice medicine and to be caring and care about people without sitting back and wondering, which one is going to be the one that totally destroys me with a malpractice suit? Those are realities.

Mr. HASTERT. Then are you saying that because of the risk, in the high risk areas of infant mortality and under weight babies and this situation, that actually the risk of caring for those people is a higher insurance peril than actually dealing with the normal population?

Dr. FRAED. Exactly.

Mr. HASTERT. So it is really a catch-22 situation, is it not?

Dr. FRAED. Yes. But it is really very sad. When I entered obstetrics 13 years ago and did my residency, obstetrics was known as the happy specialty. It has become an absolute nightmare, and as I go to meetings across the country for continuing education, I hear the same thing from all the people at the meeting. They are becoming paranoid, they are becoming angry, they are no longer caring for their patients in the type of way they wanted to care for them when they started to run into it. You cannot afford to become personally involved because that same patient is going to turn around and sue you.

And all of a sudden, you know, as much as they want to say, well, this is my job, it is just a job. It is not just a job to us and it is not just a job to me.

If you tell me I have hurt your baby, it is hard for me to go home and sleep. You cannot imagine what it is like to deliver a baby that is in trouble and wonder, is there something I could have done differently? First of all, you are beset with those feelings. You know, here is this baby and it is bad. Could I have done anything different to prevent this? And at the same time you turn around, and you are sitting there feeling insecure in the first place. The next thing you know you have got a lawyer calling you to say, "Well, you didn't do something right, doctor, there is something wrong with this baby."

Mr. HASTERT. I understand. It is not an exact science. One last question, Mr. Chairman.

Ms. Reardon, do you see--we have talked about the malpractice route and I think I understand that. Do you see any ways that the bureaucracy—the money in the system and how it is delivered, that it can be improved from your point of view?

Ms. REARDON. I am sorry, I do not have that answer for you. I wish I did. All I know is that the number of women that I see continues to increase for many reasons. The number of doctors who are willing to provide care for those women remains a very small number. And I just do not know how to make that better. I do not know what reforms need to be introduced. But I do know it is a very, very complex issue.

Mr. HASTERT. Thank you very much. Thank you, Mr. Chairman.

Chairman MILLER. Thank you. Let me ask you, do you have a waiting list in the Urban League's WIC program?

Ms. HICKMANN. Not for pregnant mothers, but we do for Priority 5 who are children who have no medical——

Chairman MILLER. You are not seeing the older children?

Ms. HICKMANN. Right. The 1 to 5 year olds, as soon as they turn a year old, then they go into a different priority and they could possibly go onto a waiting list. And we do currently have a Priority 5 waiting list.

Chairman MILLER. Thank you. Let me just raise this as an issue. We are running out of time for this panel, but maybe you can respond here, or one of the upcoming witnesses can respond to the question, when we look at malpractice insurance for some of these problems, we have been around this in other institutions that serve low income people. When you really look at it, what you find out is that low income people seem to be the least likely to engage in a lawsuit.

We looked at this in terms of child care and all of the problems we are having with securing malpractice for child care providers and day care providers. And I just wondered if there is any discussion of that. Because it appears as you have had medical malpractice rates skyrocket, poor people have been knocked out of health care. And the question is whether or not that was attributable to low income people, or people on Medicaid, who are suing or not.

Now, I understand the total cost of the doctor is the same. You are looking for services that you can get reimbursed, but it just seems to me that when we shift the burden here there is some question of whether or not we made the decision, we are going to knock low income people out because they do not bring any revenue to the office, but in fact they may not be the people who are

most likely to sue. Because when we looked at it in the past we find in many instances these are the people least likely, for all of the reasons that they cannot get access to medical care, they are having problems getting access to legal care.

So I just raise that as an issue, because it would be important for us to know whether or not this population has received greater and greater restraints on their access to health care, and one of the concerns is the increase in medical malpractice premiums. What is the correlation in terms of their frequency of use of that effort. Anybody have any——

Ms. BODEWES. In our 9-year history we only have one client that had a malpractice suit.

Ms. REARDON. But I think the sheer economics of it are such that, you know, if that malpractice rate can be spread over your number of patients that you deliver——

Chairman MILLER. Well, I understand that.

Ms. REARDON. When you are talking about aid and you are looking at that account, that is not even going to cover your lights and your heat and your staff salaries. You drop those people because they really are not able to carry their share of the burden. I would also say that access to legal services for a women with a med/mal suit is a great deal easier than accessing medical services. And I will say that as a lawyer's wife.

Chairman MILLER. Well, that is because we produce so many more attorneys. We are all looking around to see what is going on.

Dr. FRAED. I would like to address that briefly. In 10½ years of practice I have had one obstetric malpractice case. It was a case in which I was called in at the last minute by a family practitioner. When I got there the baby was delivered, and it was a Public Aid case, and I did not ask where the patient was when I was called.

In my area the cases that seem to be being filed are more Public Aid than anything else. And, again, Public Aid patients are at higher risk, which puts them at higher legal risk as well, and they do not seem to have any trouble finding attorneys to do that.

Chairman MILLER. I would be interested in knowing the answer to that. Thank you very much for your time and your testimony here this morning.

Panel 2 will be made up of Sandra Landis, who is executive director of Planned Parenthood for the Springfield area; Sharon Eisenstein, who is the director of Social Services for the Southern Seven Health Department, and Project Director, Parents Too Soon; and Dr. James Singleton, who is an obstetrician from Springfield; Dr. Edward Fesco who is the president of the Illinois State Medical Society; and Barbara Burke Dunn, who is the executive director of the Community Health Improvement Center out at Decatur.

Welcome to the committee, and your prepared statements will be placed in the record in their entirety. And we will take you, Ms. Landis, in the order in which we called your names.

We have about an hour, so if you could keep that in mind so that we leave time for questions by members of the committee. Ms. Landis, we will start with you.

## STATEMENT OF SANDRA LANDIS, EXECUTIVE DIRECTOR OF PLANNED PARENTHOOD, SPRINGFIELD AREA, SPRINGFIELD, IL

Ms. LANDIS. Thank you, Chairman Miller, and distinguished members of the Select Committee on Children, Youth, and Families.

My name is Sandra Landis, and I am executive director of Planned Parenthood, Springfield area. I am pleased to be included in this very important hearing today, and I commend the committee for your efforts. I feel that your presence here attests to your deep concern and your willingness to share with us and help solve the problems regarding infant mortality.

I come before you as an advocate for the women that we serve at Planned Parenthood, Springfield area, and as a proponent of basic preventive health care services. It is from this perspective that I will speak today. My remarks will be primarily directed to exploring how the family planning network can play a significant role in the reduction of infant mortality.

Before I address that particular topic, however, I would like to acknowledge my deep concern regarding the availability of early and comprehensive prenatal care for the Medicaid-eligible and the low income women in this community particularly.

Planned Parenthood, Springfield area, serves some 400-plus women each year who choose to carry their pregnancies to term. Securing prenatal care for these women is a serious problem. Few physicians accept Medicaid eligible or low income women, as has been attested to by everyone else. While we currently have two physicians who are willing to accept our referrals. We have had in the past, though, times when we have had no physician who was willing to take a low income or Medicaid-eligible woman. Or, times when the wait is anywhere from 8 to 12 weeks or the initial fee, as has been mentioned before, is prohibitive for that particular woman.

What happens, oftentimes, is that when a woman is faced with this situation, particularly a young adolescent woman who has few resources and lacks perhaps assertive skills to deal with the situation, there is a tendency to give up or postpone any kind of prenatal care, perhaps until there is a problem, or she is ready to deliver.

Unfortunately, at Planned Parenthood we do not have the funds available to hire the staff to follow up on these women once they leave our agency. We often get reports back from the women and the difficulty they are having. We try to refer them to other sources and oftentimes we use Care Center because they may have a physician when we do not.

The issues of low Medicaid reimbursement for prenatal care and delivery and the malpractice insurance crisis are prime factors in the willingness and the ability of physicians to accept low income women. These issues must be dealt with in a forthright manner, both at the Federal, local, and State levels. I urge you to give considerable time in addressing these barriers to much needed prenatal care.

I want to move on now to talking about exploring the Family Planning Network and how we can help.

Let me say at the outset that I speak for Planned Parenthood, Springfield area, as one member of the Family Planning Network in the State of Illinois. I firmly believe, however, that this network possesses unique characteristics that can be utilized to expand services necessary to reduce infant mortality.

Family planning clinics in the State are essential providers of preventive health care to the poor, the working poor, and those closed off from the private health care system. I might mention that Planned Parenthood, Springfield area serves around 4,400 women each year. Eighty-six percent of those women are 200 percent or below the level of proverty. Sixty-six percent are below 150 percent.

Often Family Planning is the first entry into the health care system for a large number of at-risk individuals. We offer a broad range of health care and education services. For instance, core family planning services provide general medical examinations and assessment with emphasis on reproductive health. We offer contraceptive services, pregnancy diagnosis and counseling, diagnosis and treatment of sexually transmissible diseases, hypertension screening, cancer screening, pap tests, breast exam, self-exam teaching, hematocrits, urinalysis, early illness detection, assessment of and education on nutrition, smoking, drugs. All of these things are a part of what we need to do in terms of contraceptive care. Parenting education—we offer child-parent sex communication skills. Many of us provide a large range of services to high risk teens. Probably no other system in the State of Illinois serves more teenagers than the Family Planning Network.

In addition, family planning clinics have well developed education departments that involve outreach programming and linkages to churches, schools, and other consumer-serving agencies. Family planning education services encourage the participation of individuals in their own health care, and we promote health behaviors such as planning for childbearing, avoiding unintended pregnancy, seeking early care.

The Family Planning Network is an established network that is capable of adding services given adequate resources. One of the services that could be added would be an outreach program to serve pregnant teens. Such a program would utilize an outreach nurse/educator who would provide ongoing support and education on nutrition, fetal development, labor and delivery, breastfeeding, newborn care, and parenting skills during the prenatal period. This must be coupled with an ongoing postnatal program using the same type of educator, a parenting educator, to continue the support and the education on such issues as infant stimulation, feeding and nutrition, toilet training, accident prevention, immunizations, and developmental milestones. I believe that these programs would result in significant reduction in the maternal complications and low birth weight babies of this particular population.

Many family planning clinics would be capable of developing prenatal programs providing easy access to the women that we already serve. Various models could be established from on-site services utilizing trained nurse practitioners and nurse midwives, to providing space for clinics sponsored by, a health department or a local hospital.

Family planning clinics are ideal sites for WIC-type programs since many of us already have well-developed educational programs. This could be combined with the prenatal care or the outreach program for teens. And I think we are also set up in terms, then, of easy access to contraceptive care after delivery.

Other possibilities include well-baby care, vocational counseling, identification and followup for adolescents at high risk for pregnancy.

The clinic network has no financial capability to expand its services and programs unless adequate funds are available. It will cost money. In the long run, however, these preventive services are a low-cost investment allowing the state to save more money in the long run than it would spend, more money than it would spend, for instance, in terms of the high cost of intensive perinatal care, social services, welfare dependency, and so forth.

In summary, I would like to say that family planning is a basic physical health measure, the acknowledged first line of defense for both maternal and child health. It is one of the best protectors available aganst low birth weight and other poor pregnancy outcomes. The Family Planning Network is a well established primary prevention health care partner in the battle to reduce infant mortality and it is capable of providing innovative programs and services to help fill in the gaps where needed.

Thank you for this opportunity to express my views. I hope that these remarks are informative and will stimulate further discussion and investigation.

I will be happy to answer any questions that you mght have later.

[Prepared statement of Sandra M. Landis follows:]

PREPARED STATEMENT OF SANDRA M. LANDIS, EXECUTIVE DIRECTOR, PLANNED PARENTHOOD SPRINGFIELD AREA, SPRINGFIELD, IL

Chairman Miller and other distinguished members of the Select Committee On Children, Youth and Families:

My name is Sandra Landis, Executive Director of Planned Parenthood Springfield Area. I am pleased to be included in this very important hearing on "The Continuing Infant Mortality Crisis in Illinois." Your presence here today attests to your willingness to be partners with us as we seek solutions on what can be done to improve maternal and child health in the state of Illinois.

I come before you as an advocate for the women we serve and as a proponent of basic preventive health care services. It is from this perspective that I speak today. My remarks will be primarily directed toward exploring how the family planning network can play a significant role in the reduction of infant mortality.

Before I address that topic, however, I would like to acknowledge my deep concern regarding the availability of early and comprehensive prenatal care for medicaid eligible and low income women. Planned Parenthood Springfield Area serves some four hundred plus women each year who choose to carry their pregnancies to term. Securing prenatal care for these women is a serious problem here in Springfield. Few physicians will accept medicaid eligible or low income women. While we currently have two physicians willing to accept our referrals, there have been times when no physician was available, or the wait was anywhere from eight to twelve weeks, or the fee was prohibitive. To many women, particularly a young adolescent who has few resources and may lack assertive skills to deal with the situation, this can feel like an unsurmountable task. She may "give up" and postpone care until a problem develops or she is ready to deliver. Unfortunately, we do not have funds available to hire staff to follow-up on women once they leave our agency.

The issues of low medicaid reimbursement for prenatal care and delivery and the malpractice insurance crisis are prime factors in the willingness or ability of physicians to accept low income women. These issues must be dealt with in a forth right manner both at the federal and state levels. I urge you to give considerable time to addressing these barriers to much needed prenatal care.

Exploring the Family Planning Network and How We Can Help

Let me say at the outset that I speak for Planned Parenthood Springfield Area as one member of the family planning network in the state of Illinois. I firmly believe, however, that this network possesses unique characteristics that can be utilized to expand services necessary to reduce infant mortality.

Family planning clinics in the state are essential providers of primary preventive health to the poor, working poor and those closed off from the private health care system. Often, family planning is the first entry into the medical care system for a large number of at-risk individuals. We offer a broad range of health care and education services. For example, core family planning services provide general medical examinations and assessment, with emphasis on reproductive health; contraceptive services; pregnancy diagnosis and counseling; diagnosis and treatment of sexually transmissible diseases; hypertension screening; cancer screening--pap tests, breast exam/self-exam teaching; hematocrit; urinalysis; early illness detection; assessment of and education on nutrition, smoking, drugs; parenting education; parent-child sex education. Many of us provide a range of services for high risk teens. Probably no other system in the state serves more teenagers than the family planning network.

In addition many family planning clinics have well developed education departments that involve outreach programming and linkages to churches, schools, and other consumer-serving agencies. Family planning education services encourage the participation of individuals in their own health care and promote health behaviors such as planning for childbearing, avoiding unintended pregnancy, seeking early care.

The family planning network is an established network that is capable of adding services, given adequate resources.

One such service could be an outreach program to serve pregnant teens. Such a program would utilize a nurse/educator who would provide ongoing support and education on nutrition, fetal development, labor and delivery, breastfeeding, newborn care and parenting skills during the prenatal period. Coupled with an on-going postnatal program using a parenting educator to continue support and education on such issues as infant stimulation, feeding and nutrition, toilet training, accident provention, immunizations, developmental milestones, I believe we would see significant reductions in maternal complications and low birthweight babies in this population.

Many family planning clinics would be capable of developing prenatal programs providing easy access to women we already serve. Various models could be established from on site services using trained nurse practitioners and nurse midwives, to providing space for the operation of a clinic sponsored by a local hospital or health department.

Family planning clinics are ideal sites for WIC programs since many of us already have well developed educational programs. This could be combined with a prenatal care program or outreach program for pregnant adolescents. Women would have easy access to contraceptive care when needed.

Other possibilities include well baby care, vocational counseling, identification and follow-up for adolescents at high risk for pregnancy.

The clinic network has no financial capacity to expand services and programs, however, unless adequate funds were available. It will take money. In the long run, however, these preventive services are a low-cost investment, allowing the state to save more than it would spend. (State money that would be spent for high cost intensive perinatal care, social services, welfare dependency, etc.)

In summary, family planning is a basic physical health measure--the acknowledged first line of defense for both maternal and child health.

It is one of the best protectors available against low birth weight and other poor pregnancy outcomes. The family planning network is a well established primary prevention health care partner in the battle to reduce infant mortality and is capable of providing innovative programs and services to help fill in the gaps where needed.

Again, thank you for the opportunity to express my views. I hope my remarks today have been informative and will stimulate further discussion and investigation.

Chairman MILLER. Thank you. Sharon Eisenstein. And again, your full statement will be placed in the record and the extent to which you can summarize, we will appreciate it. Thank you.

**STATEMENT OF SHARON A. EISENSTEIN, DIRECTOR OF SOCIAL SERVICES, SOUTHERN SEVEN HEALTH DEPARTMENT; PROGRAM DIRECTOR, PARENTS TOO SOON PROGRAM, ULLIN, IL**

Ms. EISENSTEIN. Good morning. My name is Sharon Eisenstein and I am the Project Director for the Illinois Department of Public Health Parents Too Soon Demonstration Project, and Illinois Department of Children and Family Services Ounce of Prevention Program at Southern Seven Health Department. Both programs are funded through the State of Illinois Parents Too Soon Initiative.

Southern Seven Health Department is a local public health authority for the southern seven counties in the State of Illinois. The seven counties form the southernmost tip of the State with the Ohio and Mississippi Rivers forming its borders between Kentucky and Missouri respectively. The counties are largely rural and cover approximately 2,000 square miles. There are no cities or towns over 8,000 in population within this area and the best example I can provide to illustrate the rural nature of the area is that in those 2,000 square miles there is only one McDonald's.

About 75 percent of the housing and 74 percent of the population is considered to be rural. Inherent to the rural nature of the area are the expected problems of high unemployment, high poverty, lack of adequate housing, inadequate public transportation, and lack of accessible quality medical services. All of the above factors contribute to the above average rates of teenage pregnancy, low birth weight, and infant mortality experienced in southern Illinois.

Infant mortality has been shown to be directly related to the incidence of low birth weight. Infants who weigh less than 5½ pounds at birth are 40 times more likely to die before the age of 1 month, and 20 times more likely to die before the age of 1 year, than those infants who weigh more than 5½ pounds.

Furthermore, two-thirds of all infants who die weighed less than 5½ pounds at birth. If the incidence of low birth weight can be reduced, then the rate of infant mortality can be impacted upon.

Numerous socioeconomic and demographic factors have been shown to be associated with the risk of low birth weight. Factors such as race, maternal age, socioeconomic status, education, and marital status all play a role in determining risk for delivery of a low birth weight infant.

According to the national statistics the low birth weight problem is especially serious in the black population. Black women are nearly twice as likely as white women to deliver a low birth weight infant. Women who reside in rural areas are at particularly high risk of experiencing this problem.

There are also certain behavioral and environmental factors that have an influence when it comes to risk for low birth weight. Smoking, the use of drugs or alcohol, low maternal weight gain, obstetric complications, and inadequate accessibility to early quality

prenatal care have a significant effect upon the incidence of low birth weight and subsequently upon infant mortality.

In working with the Parents Too Soon Program since 1984 it has been my experience that of the above behavioral and environmental factors, access to quality prenatal care is oftentimes one of the most difficult to overcome. In the 2,000-square-mile area served by Southern Seven Health Department, there is not one hospital which provides delivery services. In fact, in the southernmost counties of Alexander and Pulaski, where we see the highest rates of unemployment, Public Aid dependency, and low income in the State of Illinois, only emergency medical services are available as the community hospital closed its doors in December 1986.

There are currently three doctors in the Southern Seven counties which provide prenatal care. However, one of these doctors limits services to Medicaid recipients who reside in the three counties surrounding the one in which he practices. The other two doctors practice out of the two federally funded Rural Health Initiative clinics located in Cairo and Anna, IL.

The two clinic doctors began providing services in August of this last year. For approximately 1 year prior to this time there was only one doctor in the area which provided prenatal care. This ob/gyn was then accepting Public Aid clients from the entire seven-county area, but on July 22 our Department received a letter saying that he would no longer be accepting prenatal patients who were not "full pay" unless they reside in the previously mentioned counties. And I have attached a copy of his letter to this testimony.

Prenatal care delivered through the federally funded clinics currently provide services for approximately 45 to 50 women who are due to deliver in a given month. This clearly falls short in providing prenatal care to a seven-county area. The women who are not able to secure services through the clinics must travel an average of 40 to 60 miles one way for prenatal care. All women who live in the seven-county area travel this distance while in labor in order to obtain delivery services.

Traveling this distance while in labor or in the latter stages of pregnancy is uncomfortable at best. And I would like to add that about a month ago we had a baby delivered in a helicopter due to the vast difference between where a person resides in our area and where they have to go for delivery services.

For those women who are able to provide full payment for services the distance traveled for prenatal care is much less. This care is available in the neighboring States of Kentucky and Missouri. However, the doctors in these areas do not accept the Illinois medical card. In most cases it is the Medicaid reimbursement rates and time-consuming paperwork that are cited as the reason for limiting services.

Through funding received from the Illinois Department of Public Health Parents Too Soon and Families With a Future programs, Southern Seven Health Department has been able to institute a transportation service for women who are unable to find a way to prenatal care. This service is free of charge to residents of the seven-county area.

In addition to providing transportation services for pregnant women, the Department offers several educational, financial, and

social service programs to residents of the area. To demonstrate how these services can significantly improve pregnancy outcomes, I would like to focus on some of the success that we have experienced with the Parents Too Soon Program.

Southern Seven Health Department first began providing comprehensive services for pregnant and parenting teens in January of 1984. Services provided include case management, prenatal and parenting education, financial assistance for prenatal, delivery and hospital costs associated with pregnancy, individual counseling, referral and linkage to area services, and home visiting. Transportation is available for each type of service provided.

To obtain financial assistance a teen must first apply for Medicaid assistance through the Illinois Department of Public Aid. If either a denial or a spend-down is determined and the teen's income falls within 185 percent of the poverty level, she is determined eligible for Parents Too Soon financial assistance.

Parents Too Soon has secured agreements with several physicians and hospitals in Illinois who will accept payment from the program. Payment is made at the current Illinois Department of Public Aid reimbursement rates. Although this rate is one-third to one-half that of full payment, Parents Too Soon has been fortunate in securing doctors due to the 30-day turnaround time in which billing is processed. In addition to the quick payment schedule physicians are assured that their teen client who participates in Parents Too Soon will comply with meeting appoint schedules and that they may call upon Program staff should any problems occur.

Parents Too Soon services continue through the Ounce of Prevention Home Visiting Program until each infant reaches the age of 18 months. Program staff ensure that each child's medical needs are met and help the young mothers to increase their parenting skills.

Although my description of program services has been condensed in this testimony I am sure that it is clear a lot of staff are necessary to conduct such a project. The Parents Too Soon staff consists of 10 direct service providers. It is a multidisciplinary staff which includes five social workers, two nurses, two case advocates, and a nutritionist.

The success of the program in relation to infant mortality has been tremendous. Since the inception of programming 424 infants have been delivered to adolescents participating in the program. At this time every child is still living. The program's 0 percent mortality rate falls well below the 17.3 percent rate experienced in the seven county area for children who were born in 1984. This is the most recent year for which I have statistics.

The program has also experienced success in the area of reducing low birth weight with a 6-percent ratio in fiscal year 1987.

In a rural area such as southern Illinois services which increase accessibility to quality prenatal care and provide the followup necessary to ensure that women refrain from those behaviors which increase the chances for negative pregnancy outcomes are essential in order for infant mortality rate to decline.

However, these programs would be useless without available medical care for those pregnant women who live in poverty. Southern Seven Health Department has been lucky in securing prenatal

care for women in the seven county area. Oftentimes it is only upon a referral from the Department that a woman who lives in the area and is on Public Aid can secure such care.

As with the doctor who was mentioned earlier in my statement, many physicians are beginning to provide care only to those women who reside in the county in which they practice. For women who live in an area where prenatal care is so limited, availability of medical services is becoming increasingly scarce.

As malpractice insurance rates for doctors who provide delivery services continue to skyrocket, the number of doctors who remain in the field declines. This creates a greater demand for care by that segment of the population who has insurance or can pay the full price. What physician is going to accept Public Aid patients over one who will pay over twice the rate of Public Aid reimbursement, especially when this reimbursement for care cannot meet the insurance costs?

When care is provided for a high risk patient, the discrepancy is even greater as the cost of increased care is not reflected in increased reimbursement. Medicaid policies and reimbursement rates need to be revised to reflect the high risk nature of the Medicaid-eligible population.

Every day Americans spend millions of dollars to provide care for babies born too early, too sick, or too small to have the best chance for a healthy productive life. In 1978 the estimated cost to taxpayers for neonatal intensive care for just one high risk infant was $13,616. Even when comparing this figure to the cost of quality prenatal care today, the savings to taxpayers is clear.

Included in the Surgeon General's goals for the United States in the area of maternity care is that of reducing the rate of infant mortality to 9 infant deaths per 1,000 live births by the year 1990. If this goal is to be met more programs such as those instituted in the State of Illinois need to be implemented in conjunction with those necessary changes in public policy that will increase the availability of quality medical services for the medically indigent.

I would like to close with this excerpt from the Children's Defense Fund's Children's Defense Budget for 1988:

> Our Nation's failure to meet the Surgeon General's 1990 goals means we will experience 300,000 more low birth weight births between 1978 and 1990 than would have occurred had the goals been met. The hospital costs of caring for these additional infants in their first year alone will be more than $2 billion by the end of this decade, enough to provide the following: 60,109,443 WIC monthly supplemental food packages; comprehensive prenatal care to 3,187,000 women; comprehensive maternity and delivery costs to 701,000 women; or comprehensive basic pediatric care to 4,207,661 additional infants and children.
>
> These excess costs do not take into account the long-term medical, educational, and social services that the low birth weight babies will need, nor their lost productivity to the nation.

Thank you.

[Prepared statement of Sharon A. Eisenstein follows:]

PREPARED STATEMENT OF SHARON A. EISENSTEIN, DIRECTOR OF SOCIAL SERVICES, SOUTHERN SEVEN HEALTH DEPARTMENT, ULLIN, IL

Good Morning,

My name is Sharon Eisenstein, I am the project director for the Illinois Department of Public Health Parents Too Soon Demonstration Project and the Illinois Department of Children and Family Services Ounce of Prevention Program at Southern Seven Health Department. Both programs are funded through the State of Illinois Parents Too Soon Initiative.

Southern Seven Health Department is the local public health authority for the southern seven counties of Alexander, Johnson, Massac, Pope, Pulaski, and Union in the state of Illinois. The seven counties form the southernmost tip of the state with the Ohio and Mississippi rivers forming it's borders between Kentucky and Missouri respectively.

The counties are largely rural covering approximately 2,000 square miles with no cities or towns over 8,000 in population. To provide an example which fully illustrates the rural nature of the area I can add that within these 2,000 square miles there is only one McDonalds.

Seventy-five percent (75%) of the population and seventy-four (74%) of the housing is considered to be rural with only three of the thirty-three incorporated townships having popuations in excess of 2,000. The population of the remaining thirty townships ranges from sixty-seven to thirteen hundred (1980 census).

Inherent to the rural nature of the area are the expected problems of high unemployment, high poverty, lack of adequate housing, inadequate public transportation, and lack of accessible quality medical services. All of the above factors contribute to the above average rates of teenage pregnancy, low birthweight and infant mortality experienced in southern Illinois.

Infant mortality has been shown to be directly related to the incidence of low birthweight. Infants weighing less than five and one half pounds are 40 times more likely to die before the age of one month and 20 times more likely to die before the age of one year than those infants with a birth weight above five and one half pounds. Furthermore, two-thirds of all infants who die weighed less than five and one half pounds at birth.[1] If the incidence of low birthweight can be reduced, the rate of infant mortality can be impacted upon.

Numerous socioeconomic, and demographic, factors have been shown to be associated with the incidence of low birthweight. Factors such as race, maternal age, socioeconomic status, education, and marital status all play a role when determining risk for delivery of a low birthweight infant.

According to national statistics, the low birthweight problem is especially serious in the black population; black women are nearly twice as likely as white women to deliver a low birthweight infant. Women residing in rural areas are at particularly high risk of experiencing this problem. It is thought that the cumulative effects of generations of poverty and low socioeconomic status account for these racial differences. [2]

Certain behavioral and environmental factors also have an influence when it comes to risk for low birthweight. Smoking, the use of drugs or alcohol, low maternal weight gain, obstetric complications, and inadequate accessibility to early quality prenatal care have a significant effect upon the incidence of low birthweight and susequently upon infant mortality.

In working with the Parents Toon Soon program since 1984, it has been my experience that of the above behavioral and environmental factors, access to quality prenatal care is often times one of the most difficult to overcome.

In the 2,000 square mile area served by Southern Seven Health Department, there is not one hospital which provides delivery services. In fact, in the southernmost counties of Alexander and Pulaski, (where we see the highest rates of unemployment, public aid dependency, and low income in the state of Illinois) only emergency medical services are available as; the community hospital closed it's doors in December of 1986.

There are currently three doctors in the southern seven counties which provide prenatal care. However, one of these doctors limits services to medicaid recipients who reside in the three counties surrounding the one in which he practices. The other two doctors practice out of the two federally funded rural health initiative clinics located in Cairo and Anna Illinois.

The two clinic doctors began providing services in August of 1987. For approximately one year prior to this time, there was only one doctor in the area providing services. This OB/GYN was then accepting public aid clients from the entire area, but on July 22, 1987 the department received a letter stating that he would no longer be accepting prenatal patients who were not "full pay" unless they reside in the previously mentioned counties. A copy of this letter is attached as exhibit A.

Prenatal care delivered through the federally funded clinics currently provides services for approximately 45-50 women due to deliver in a given month. This clearly falls short in providing prenatal care to a seven county area. The women who are not able to secure services through the clinics must travel an average of 40-60 miles one-way for prenatal care. All women who live in the seven county area travel this distance while in labor in order to obtain delivery services. Traveling this distance while in labor or in the latter stages of pregnancy is uncomfortable at best.

For those women who are able to provide full payment for services, the distance traveled for prenatal care is much less. This care is available in the neighboring states of Kentucky and Missouri. However, doctors in these areas do not accept the Illinois medical card. In most cases, it is the low medicaid reimbursement rates and time consuming paper work that is cited as the reason for limiting services.

Through funding received from the Illinois Department of Public Health Parents Too Soon and Families With A future Programs, Southern Health Department has been able to institute a transportation service for women who are unable to find a way to prenatal care. The service is free of charge to residents of the seven county area.

In addition to providing transportation services to pregnant women, the department offers several educational, financial and social service programs to residents of the area. To demonstrate how these services can significantly improve pregnancy outcomes, I would like to focus on some of the success we have experienced with the Parents Too Soon (PTS) Program.

Southern Seven Health Department first began providing comprehensive services for pregnant and parenting teens in January of 1984. Services provided include: case management, prenatal and parenting education, financial assistance for prenatal, delivery and hospital costs associated with pregnancy, individual counseling, referral and linkage to area services, and home visiting. Transportation is available for each type of service provided.

To obtain financial assistance, a teen must first apply for medical assistance throughthe Illinois Department of Public Aid. If either a denial or a spend-down is determined and the teen's income falls within 185% of the poverty level, she is then determined eligible for PTS financial assistance. PTS has secured agreements with several physicians and hospitals in Illinois who will accept payment from the program.

Payment is made at the current Illinois Department of Public Aid reimbursement rates. Although this rate is one-third to one-half that of full payment, PTS has been fortunate in securing doctors due to the thirty-day turn around time in which billing is processed. In addition to the quick payment schedule, physicians are assured that their teen client who participates in PTS will comply with meeting appointment schedules and that they may call upon program staff should any problems occur.

PTS services continue through the Dunce of Prevention home visiting program until each infant reaches the age of 18 months. Program staff insure that each child's medical needs are met and help the young mothers to increase their parenting skills.

Although my description of program services has been condensed in this testimony, I am sure it is clear that a lot of staff are necessary to conduct such a project. The PTS staff consist of ten direct service providers. It is a multi-disciplinary staff which includes five social workers, two nurses, two case advocates, and a nutritionist.

The success of the program in relation to infant mortality has been tremendous. Since the inception of programming, 424 infants have been delivered to adolescents participating in the project. At this time, every child is still living. The program's 0% infant mortality rate falls well below the 17.3% rate experienced in the seven county area in 1984, the most recent year for which statistics are available. (Ill. Dept. of Public Health, Vital Statistics, 1985.)

The program has also experienced success in the area of reducing low birthweight with a 6% ratio in fiscal year 1987 (7/1/86-6/30/87).

In a rural area such as southern Illinois, services which increase accessibility to quality prenatal care, and provide the follow-up necessary to ensure that women refrain from those behaviors which increase the chances for negative pregnancy outcomes, are essential in order for the infant mortality rate to decline.

However, these programs would be useless without available medical care for those pregnant women who live in poverty. Southern Seven Health Department has been lucky in securing prenatal care for women in the seven county area. Oftentimes, it is only upon a referral from the department that a woman who lives in the area and is on public aid is able to secure such care.

As with the doctor who was mentioned earlier in my statement, many physicians are beginning to provide care only to those women who reside in the county in which they practice. For women who live in an area where prenatal care is so limited availability of medical services is becoming increasingly scarce.

As malpractice insurance rates for doctors who provide delivery services continue to skyrocket, the number of doctors who remain in the field declines. This creates a greater demand for care by that segment of the population who has insurance or can pay the full price. What physician is going to accept a public aid patient over one who will pay over twice the rate of public aid reimbursement? Especially when reimbursement for care can not meet the insurance cost.

When care is provided for a high risk patient the discrepancy is even greater as the cost of increased care is not reflected in increased reimbursement. Medicaid policies and reimbursement rates need to be revised to reflect the high-risk nature of the Medicaid eligible population.

Everyday Americans spend millions of dollars to provide care to babies born too early, too sick, or too small to have the best chance for a healthy, productive life. In 1978, the estimated cost to taxpayers for neonatal intensive care for just one high-risk infant was $13,616.[3] Even when comparing this figure to the cost of quality prenatal care today the savings to taxpayers is clear.

Included in the Surgeon General's goals for the United States is in the area of maternity care is that of reducing the rate of infant mortality to 9 infant deaths per 1,000 live births by the year 1990. If this goal is to be met more programs such as those instituted in the state of Illinois need to be implemented in cojunction with those necessary changes in public policy that will increase the availability of quality medical services for the medically indigent.

I would like to close with this excerpt from the Children's Defense Fund's, Children's Defense Budget for fiscal year 1988. "Our nation's failure to meet the Surgeon General's 1990 goals means we will experience 300,00 more low-birthweight births between 1978 and 1990 than would have occured had the goals been met. The hospital costs of caring for these additional infants in their first year alone will be more than $2 billion by the end of this decade- enough to provide the following: 60,109,443 WIC monthly supplemental food packages; comprehensive prenatal care to 3,187,000 women; comprehensive maternity and delivery costs to 701,000 women; or comprehensive basic pediatric care to 4,207,661 additional infants and children."[4]

"These excess costs do not take into account the long-term medical, educational, social, and other services that the low-birthweight babies will need, nor their lost productivity to the nation."[5] Thank-you.

EXHIBIT A

David L. Grimes, III, M.D., F.A.C.O.
1515 LONE OAK ROAD
SUITE 2
PADUCAH, KENTUCKY 42003
TELEPHONE (502) 444-6274

July 22, 1987

Ms. Jane Wernsmen
Director of Nursing
Southern Seven Health Dept.
RR 1 Box 53A
Ullin, IL 62992

Dear Jane;

As you are aware, the malpractice crisis is taking its toll on obstetricians in the southern Illinois area. I have had to limit my practice of IDPA patients and Parents Too Soon program to just the three surrounding counties of Massac, Pope, and Johnson. Because of the large increase insurance and no incraese in the amount of reimbursement to offset this, I have found that I have had to cut back on the number of patients that I am able to provide care because of the financial burden that this places on my practice. The recent lack of IDPA funds and the probability that this is going to continue to occur and that the legislature is talking about decreasing rather than increasing IDPA benefits, requires that I reevaluate accepting these patients for care. My charge of $1200.00 for Total OB Care and Vaginal Delivery and $1600.00 if a C-Section is necessary is well below the national and Illinois average. However with Illinois only reimbursing approximately 450.00 for a vaginal delivery I find that this is not a sufficient amount to offset my fixed overhead costs including the rapid rise in my malpractice premium. Since I am one of few physicians providing obstetric care in the southern Illinois region, I feel it is important to notify you of the possibility that I may be forced to discontinue rendering obstetric care to IDPA and Parents Too Soon patients so that you may try to institute some alternate contingency plan for the care of these patients. Certainly multiple studies have now been done to document the increased perinatal mortality and morbidity in this area and numerous programs have been undertaken to try to correct this. However it seems that the single most important factor in this, which is the obstetrician taking care of these patients, has not been dealt with in any practical manner.

I am currently receiving a large amount of pressure from my pediatric colleagues and from hospital administration because of their frustration in totally inadequate reimbursement here in Kentucky from rendering care to IDPA patients. My commitment to accepting a patient to be followed also unilaterally commits Western Baptist Hospital and the pediatricians in this area into caring for these patients.

Numerous letters from the pediatricians to Gov. Thompson and to the IDPA program seems to have fallen on deaf ears. It is unfortunate that politicians seem to only be willing to deal with crisis situations rather than averting a problem before it develops. As you know from the experience in the Cairo area it is becoming very difficult, if not impossible to find any obstetrician willing to remain in these areas and provide care for these patients. Any suggestions on your part will be greatly appreciated, however if the malpractice crisis continues to worsen and there is no increase to adequate levels of funding for providing care for these patients, then I will be forced to discontinue seeing them in my practice except on a full-pay basis as all of my patients are seen.

Please feel free to share my concerns with local political leaders and also political and IDPA administrators on a local and state level.

For the time being I plan to continue obstetric care to IDPA patients only in the Massac, Johnson and Pope counties but as I previously mentioned this may have to also be discontinued.

Thank you very much for consideration of this problem. Hopefully we can work together to come up with a solution that will allow good care to be continued to be rendered to these patients in order to improve preinatal morbidity and mortality rates in this area.

Sincerely,

David L. Grimes M.D.

Dr. David L. Grimes
Obstetrics and Gynecology

DLG:scm

cc: Mr. Loren Erwin

## EXHIBIT B

The following six pages comprise exhibit B. These pages consist of billing forms from an area medical provider. In column E at the lower right side the medical provider charges are indicated. Column H to the far right and in hand written documentation shows the current medicaid reimbursement rate. The six forms cover a variety of lab and other patient care costs that commonly are incurred through normal prenatal care and delivery.

17 DATE PATIENT ABLE TO RETURN TO WORK

18 DATES OF TOTAL DISABILITY FROM THROUGH

DATES OF PARTIAL DISABILITY FROM THROUGH

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (I.D. PUBLIC HEALTH AGENCY)

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED

21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

MEMORIAL HOSPITAL CARBONDALE

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES NO CHARGES

23 A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE

1. 650.0

2.

3.

4.

G EPSDT YES NO FAMILY PLANNING YES NO

PROP. AUTHORIZATION NO.

| 24 A. DATE OF SERVICE FROM TO | B. PLACE OF SERVICE | C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (CPT/HCPC) | EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES | D. DIAGNOSIS CODE | E. CHARGES | F. DAYS OR UNITS | G. TOS | H. LEAVE BLANK |
|---|---|---|---|---|---|---|---|---|
| 07/08/97 | IH | 59410. | VB - CARE AVE DELIVERY only | 650.0 | 676.00 | 1 | 2 | 304.30 |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

25 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)

ROGER N. KLAY

DATE 9/21/97

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES X NO

27 TOTAL CHARGE 676.00

28 AMOUNT PAID 0.00

29 BALANCE DUE 676.00

30 YOUR PATIENT'S ACCOUNT NO. 42222

31 YOUR SOCIAL SECURITY NO.

32 YOUR EMPLOYER I.D. NO. 372744916

33 PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.

CARBONDALE CLINIC 304.30
2201 W. MAIN
CARBONDALE, IL 62901

I.D. NO. 37-0744916 618 549 5361

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY FROM THROUGH

DATES OF PARTIAL DISABILITY FROM THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

MEMORIAL HOSPITAL CARBONDALE

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES NO CHARGES

23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE

1. SINGLE LIVEBORN-IN HOSP V30.0
2.
3.
4.

B. OPSIT YES NO FAMILY PLANNING YES NO

PRIOR AUTHORIZATION NO.

| 24. A. DATE(S) OF SERVICE FROM | TO | B. PLACE OF SERVICE | C. PROCEDURES, SERVICES OR SUPPLIES (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES) PROCEDURE (CPT/HCPCS) | MODIFIER | ICD-9-CM DIAGNOSIS CODE | $ CHARGES | D. DAYS OR UNITS | E. T.O.S. | H. LEAVE BLANK |
|---|---|---|---|---|---|---|---|---|---|
| 04/23/87 | | IH | 99200. | | V30.0 | 000 | 1 | | |
| 04/23/87 | | | HOSPITAL ADMISSION | | | | | | |
| 04/23/87 | | IH | 90225. | | V30.0 | ~~8000~~ | 1 | 1 | 34.15 |
| 04/23/87 | | | INITIAL NEW BORN CARE | E | | | | | |
| 04/23/87 | | IH | 54150. | | V30.0 | ~~4400~~ | 1 | 2 | 31.95 |
| 04/23/87 | | | CIRCUMCISION | | | | | | |
| 04/25/87 | | IH | 99201. | | V30.0 | 000 | 1 | | |
| 04/25/87 | | | HOSPITAL DISCHARGE | | | | | | |

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES) OR CREDENTIALS) & CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)

SIDNEY G. SMITH

DATE 2/26/87

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES X NO

27. YOUR SOCIAL SECURITY NO.

28. TOTAL CHARGE ~~132~~

29. AMOUNT PAID 000

30. BALANCE ~~132.~~

31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.

CARBONDALE CLINIC $66.10
2601 W. MAIN
CARBONDALE, IL 62901

32. YOUR PATIENT'S ACCOUNT NO.

03475

33. YOUR EMPLOYER I.D. NO.

372744916

I.D. NO. 37-0744916 618 549 5

AGE OF SERVICE AND TYPE OF SERVICE (E.G.) CODES ON THE BACK AREA

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (1-84) Form OWCP-1
Form CHAMPUS-501 Form RRB-150

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY FROM THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)

DATES OF PARTIAL DISABILITY FROM THROUGH

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

MEMORIAL HOSPITAL CARBONDALE

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES NO $ CHARGES

23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR 24 CODE

1. DELIVERY WITHOUT MENTION OF COMPLICATIO 650.0
2. STERILIZATION V25.2
3.
4.

B. EPSDT YES NO
FAMILY PLANNING YES NO

PRIOR AUTHORIZATION NO.

| 24. A DATE OF SERVICE FROM | TO | B. PLACE OF SERVICE | C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE SHOWN. PROCEDURE (CPT/HCPCS) CODE | MODIFIER | EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES | D. DIAGNOSIS CODE | E. CHARGES | F. DAYS OR UNITS | G. E.P.S.D.T. | H. LEAVE BLANK |
|---|---|---|---|---|---|---|---|---|---|---|
| 04/23/87 | | IH | 59410 | | CARE AND DELIVERY | 650.0 2 | 2[illegible]00 | 1 | 2 | $446.50 |
| 04/24/87 | | IH | 58605 | | DIVISION OF FALLOPIA N TUBE | 650.0 2 | 39900 | 1 | 2 | disallow |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)

ROGER N. KLAP

DATE 4/22/87

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES NO

27. TOTAL CHARGE 1218300

28. AMOUNT PAID 000

29. BALANCE DUE 1183.00

30. YOUR SOCIAL SECURITY NO.

31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.

CARBONDALE CLINIC $446.50
2601 W. MAIN
CARBONDALE, IL 62901

32. YOUR PATIENT'S ACCOUNT NO. 3012

33. YOUR EMPLOYER I.D. NO. 370744716

EIN NO. 37-0744916 618 549 53[illegible]

* PLACE OF SERVICE AND TYPE OF SERVICE (1 OR 2) CODES ON THE BACK REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (1-84) Form CHAMPUS-501 Form OWCP-1500 Form RRB-1500

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP) — 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE

17. DATE PATIENT ABLE TO RETURN TO WORK — 18. DATES OF TOTAL DISABILITY FROM / THROUGH — DATES OF PARTIAL DISABILITY FROM / THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PSRO IC HEALTH AGENCY) — 20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED / DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
OFFICE

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES

23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR 99 CODE
1. 1 NORMAL PREGNANCY — V22
2.
3.
4.

24. A. EPSDT — YES 88 NO
FAMILY PLANNING — YES ☐ NO ☐
PRIOR AUTHORIZATION NO.

| 25. A DATE OF SERVICE FROM / TO | B. PLACE OF SERVICE | C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES) PROCEDURE IDENTIFY CPT-4 | ICD-9-CM DIAGNOSIS CODE | D. CHARGES | E. DAYS OR UNITS | F. EMG | H. LEAVE BLANK |
|---|---|---|---|---|---|---|---|
| 04/30/87 04/30/87 | 0 | 59420. OBSTETRICAL-ANTEPART UM | V22 | 000 | 1 | 2 | |
| 04/30/87 04/30/87 | 0 | 81000. URINALYSIS | V22 | 675 | 1 | 5 | 3.30 |
| 04/30/87 04/30/87 | 0 | 87086. LAB-URINE/COLONY COU NT | V22 | 1500 | 1 | 5 | 11.00 |
| 04/30/87 04/30/87 | 0 | 85999. LAB-HEMATOLOGY/OB,RO UTINE | V22 | 3300 | 1 | 5 | 20.00 |
| 05/19/87 05/19/87 | 0 | 90070. EXTENDED SERV-EST PT | V22 | 6600 | 1 | 1 | 17.65 |
| | | | | | | | |

26. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
ROGER N. KLAM
DATE

27. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) X YES ☐ NO ☐

28. YOUR SOCIAL SECURITY NO.

29. YOUR PATIENT'S ACCOUNT NO.
85994

30. YOUR EMPLOYER I.D. NO.
370744916

31. TOTAL CHARGE 12575 — 32. AMOUNT PAID — 33. BALANCE D 122.75

31. PHYSICIAN'S, SUPPLIER'S, JUNIOR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO. $51.95
CARBONDALE CLINIC
2601 W. MAIN
CARBONDALE, IL 62901

I.D. NO. 37-0744916 618 549

* PLACE OF SERVICE AND TYPE OF SERVICE (1-0-1) CODES ON THE BACK REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (1-84) Form OWCP-15(
Form CHAMPUS-501 Form RRB-1500

(ACCIDENT) OR PREGNANCY (LMP)

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY FROM THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)

20. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

OFFICE

DATES OF PARTIAL DISABILITY FROM THROUGH

23. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED

25. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO CHARGES

21. A. DIAGNOSE OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, OR 4

1. NORMAL PREGNANCY V22
2. GYNECOLOGIC EXAMINATION V72.3
3.
4.

B. EPSDT YES [ ] NO [ ] FAMILY PLANNING YES [ ] NO [ ]

PRIOR AUTHORIZATION NO.

| A. DATE OF SERVICE FROM | TO | B. PLACE OF SERVICE | C. PROCEDURES, SERVICES OR SUPPLIES (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES) PROCEDURE (CPT/HCPCS) | MODIFIER | DIAGNOSIS CODE | D. CHARGES | E. DAYS OR UNITS | F. EMG | G. LEAVE BLANK |
|---|---|---|---|---|---|---|---|---|---|
| 09/10/87 | 09/10/87 | 0 | 60150 | LAB-PAP SMEAR | V22.2 | 2400 | 1 | 5 | 8.63 |
| 09/10/87 | 09/10/87 | 0 | 81000 | URINALYSIS | V22.2 | 1500 | 1 | 5 | 3.30 |

ICD-9-CM

27. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES [X] NO [ ]

28. TOTAL CHARGE 3900 29. AMOUNT PAID 000 30. BALANCE DUE 35

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)

ROGER N. KLAP

DATE 9/10/87

32. YOUR PATIENT'S ACCOUNT NO. 35467

33. YOUR SOCIAL SECURITY NO.

34. YOUR EMPLOYER I.D. NO. 370744919

PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO. $11.93

CARBONDALE CLINIC
2501 W. MAIN
CARBONDALE, IL 62901

I.D. NO. 37-0744916 618 549 5

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/83

Form HCFA-1500 (1-80) Form CHAMPUS-501 Form OWCP-15 Form RAB-1500

OFFICE

1. NORMAL PREGNANCY V22

| 24. DATE(S) OF SERVICE FROM | TO | B. PLACE OF SERVICE | C. PROCEDURES, SERVICES OR SUPPLIES (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES) CPT/HCPCS | MODIFIER | D. DIAGNOSIS CODE ICD-9-CM | E. CHARGES | F. DAYS OR UNITS | G. EPSDT FAMILY PLAN | H. LEAVE BLANK |
|---|---|---|---|---|---|---|---|---|---|
| 09/16/87 | 09/16/87 | 0 | 85025 CBC/PLT-CT/WBC | | V22 | 3800 | 1 | | 16.00 |
| 09/16/87 | 09/16/87 | 0 | 82947 GLUCOSE-FBS | | V22 | 1200 | 1 | | 5.75 |

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES) OR CREDENTIALS (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
ROGER N. KLAK
DATE 9/16/87

26. YOUR PATIENT'S ACCOUNT NO. 9C828

27. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES [X] NO

28. YOUR SOCIAL SECURITY NO.

29. YOUR EMPLOYER I.D. NO. 370744916

28. TOTAL CHARGE 5000

29. AMOUNT PAID 000

30. BALANCE DUE 50.00

31. PHYSICIAN'S, SUPPLIER'S, OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.
CARBONDALE CLINIC $21.75
2601 W. MAIN
CARBONDALE, IL 62901

I.D. NO. 37-0744916 618 549 53

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK
REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/83

Form HCFA-1500 (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

## BIBLIOGRAPHY

1. Congressional Research Servise. *Infant Mortality* (report of the Service prepared for the subcommitte on Health and the Environment of the Committee on Energy and Commerce of the U.S. House of Representatives). Washington, D.C.: 1984.

2. Committee to Study the Prevention of Low Birthweight, Division of Helath Promotion and Disease Prevention, Institute of Medicine. *Preventing Low Birth Weight: Summary.* Washington, D.C.: National Academy Press, 1985

3. Miller, C.A. Infant Mortality in the U.S. *Scientific American,* July 1985, CCL II: 31-37.

4. Childrens Defense Fund. *A Children's Defense Budget.* Washington D.C.: Children's Defense Fund, 1987, p.81.

5. Ibid.

In addition I would like to thank Jan Dorfler who in her work as the program coordinator of the Families With A Future Program at Southern Seven Health Department is in the process of writing a Needs Assessment on Infant Mortality in southern Illinois. Information contained in this assessment appears as part of this testimony. This information was used with the permission of the author.

Chairman MILLER. Thank you. Dr. Singleton.

**STATEMENT OF JAMES SINGLETON, M.D., OBSTETRICIAN, SPRINGFIELD, IL**

Dr. SINGLETON. Members of the Select Committee, participants and guests:

I thank you for this opportunity to share information about prenatal care and perinatal morbidity and mortality.

My name is Jim Singleton. I have been an obstetrician in this community for 26 years.

We know that the statistics in central Illinois are not enviable. Most of our adverse pregnancy results occur among the medically indigent. Factors that I have seen include teenage pregnancy, poor nutrition, concomitant health problems, substance abuse, and failure to obtain timely prenatal care.

Frequently these factors are associated with poverty in one way or another. Educational programs and supplementary health and food programs are required and need to be strengthened. Certainly, others have addressed these needs here this morning.

I am here today to discuss the factors influencing availability of professional obstetric care particularly for those at high risk because of economic factors.

Traditionally physicians have maintained lower fee schedules for obstetric care because most patients were in young families with limited resources. Prenatal care cannot be postponed when a young woman is pregnant. Excellent care is important from the earliest weeks of gestation.

In the past office costs were low. Obstetricians required no expensive equipment, and professional liability insurance premiums were a small part of our overhead costs. In contrast physicians providing obstetric care today are faced with astronomic expenses. Advances in prenatal care demand access to sophisticated equipment for evaluating the condition of the fetus from the earliest diagnosis of pregnancy. In addition professional liability insurance premiums are rising so rapidly that physicians and third party payors are unable to anticipate needs even a few months in advance.

Recent professional liability insurance experience in our office is illustrative and typical. We have not had an unusual number of claims. The premium for basic malpractice insurance in the year ending June 1987, was $36,500 for each physician for 12 months. The same company quoted a premium of $47,000 per physician for the next 6 months, equalling an annual increase of 257 percent. Because of this my senior associate elected to retire prematurely. One other Springfield specialist has retired early and two no longer provide obstetric care. Many family practitioners have given up obstetric care or have announced their intent to do so.

Today in Sangamon County some doctors who practice obstetrics exclude Medicaid patients completely. Most other obstetricians limit the number of Medicaid patients feeling that otherwise they would have a disproportionate number of patients for whom they are undercompensated.

Undercompensated by what definition? In 1986 the median fee paid in the United States for total obstetric care was $1,000. At

that time the Illinois Department of Public Aid paid $450 for total obstetric care in Springfield. An informal canvass of Sangamon County obstetricians indicates that office costs are approximately $650 for each obstetric patient. About $200 of this is payment for liability insurance premiums. This does not include compensation for the physician's time and expertise.

Most patients have 10 to 12 office visits and most receive night or weekend labor and delivery care in the hospital. The surest way to improve perinatal statistics is to make excellent care readily available. Provision for fair and adequate compensation for services is needed.

I believe that obstetricians would be receptive to Medicaid fee structures that realistically address costs reflecting, most importantly, medical liability insurance premiums.

At the same time, professional liability insurance costs must be controlled. This difficult problem brings up the sensitive questions of tort reform and regulation of insurance companies. Several States have legislation limiting awards for noneconomic loss and other measures that have kept insurance premiums lower.

In Indiana, for instance, obstetricians paid $9,000 last year for coverage that cost $36,500 in Springfield.

Early adequate medical care is the cornerstone of any program to improve perinatal outcome. Doctors in the obstetric field are dedicated to maternal and infant care. That is our whole reason for being in the field. We want every pregnant patient to receive optimal care.

Science has developed wonderful new ways for improved pregnancy outcome. Our legal system has methods for securing very high awards to victims of adverse outcome in pregnancies. But society has yet to find and adopt a fair and equitable way to control and pay for these spiraling costs.

Our community has the equipment, technology, the manpower and the medical expertise to provide the very best care available anywhere. Our job is to find ways to be certain that every pregnant woman can obtain this best care.

Thank you.

[Prepared statement of James Singleton, M.D., follows:]

81-031 0 - 88 - 6

## PREPARED STATEMENT OF JAMES SINGLETON, M.D., SPRINGFIELD, IL

PERINATAL MORBIDITY AND MORTALITY

Members of the Select Committee, Participants, and Guests,

I thank you for this opportunity to share information about prenatal care and perinatal morbidity and mortality. We know that the statistics in Central Illinois are not enviable. Most of our adverse pregnancy results occur among the medically indigent. Factors that are involved include teenage pregnancy, poor nutrition, concomitant health problems, substance abuse, and failure to obtain timely prenatal care. Frequently, these factors are associated with poverty in one way or another.

Educational programs and supplementary food programs are required and need to be strengthened. Certainly, others will address these needs.

I am here today to discuss the factors influencing availability of professional obstetric care, particularly for those at high risk because of economic factors.

Traditionally, physicians have maintained lower fee schedules for obstetric care because most patients were in young families with limited resources. Prenatal care cannot be postponed when a young woman is pregnant. Excellent care is important from the earliest weeks of gestation.

In the past, office costs were low. Obstetricians required no expensive equipment, and professional liability insurance premiums were a small part of the overhead costs. In contrast, physicians providing obstetric care today are faced with astronomic expenses. Advances in prenatal care demand access to sophisticated equipment for evaluating the condition of the fetus from the earliest diagnosis of pregnancy. In addition, professional liability insurance premiums are rising so rapidly that physicians and third party payers are unable to anticipate needs, even a few months in advance.

Recent professional liability insurance experience in our office is illustrative and typical. We have not had an unusual claim experience. The premium for basic malpractice insurance in the year ending June 1987 was $36,500 for one physician for twelve months. The same company quoted a premium of $47,000 per physician for the next six months, equalling an annual increase of 257%. Because of this, my senior associate elected to retire prematurely. One other specialist has retired early and two no longer provide obstetric care. Many family practitioners have given up obstetric care.

Today, in Sangamon County, some doctors who practice obstetrics exclude Medicaid patients completely. Most other obstetricians limit the number of Medicaid patients, feeling that, otherwise, they would have a disproportionate number of patients for whom they are undercompensated. Undercompensated by what definition? In 1986, the median fee paid in the United States for total obstetric care was $1,000.00. At that time, the Illinois Department of Public Aid paid $450.00 for total obstetric care. An informal canvas of Sangamon County obstetricians indicates that office costs are approximately $650.00 for each obstetric patient. This does not include compensation for the physician's time and expertise. Most patients have ten to twelve office visits, and most receive night or weekend labor and delivery care. The surest way to improve perinatal statistics is to make excellent care readily available. Provision for fair and adequate compensation for services is required. I believe that obstetricians would be receptive to Medicaid fee structures that realistically address costs, reflecting, most importantly, medical liability insurance premiums.

At the same time, professional liability insurance costs must be controlled. This difficult problem brings up the sensitive questions of tort reform and regulation of insurance companies. Several states have

legislation limiting awards for non-economic loss, and other measures that have kept insurance premiums lower. In Indiana, for instance, obstetricians paid $9,000.00 last year for coverage that cost $36,500.00 in Springfield.

Early, adequate medical care is the cornerstone of any program to improve perinatal outcome.

Our community has the equipment, technology, the manpower, and the medical expertise to provide the very best care available anywhere. Our job is to find ways to be certain that every pregnant woman can obtain the best care.

Chairman MILLER. Thank you very much. Dr. Fesco.

## STATEMENT OF EDWARD J. FESCO, M.D., PRESIDENT, ILLINOIS STATE MEDICAL SOCIETY, LA SALLE, IL

Dr. FESCO. Thank you for having us here today to hear us out. I am a physician and surgeon from La Salle, IL. I have been in practice 25 years, and I am current President of the Illinois State Medical Society.

You have my testimony. I will not belabor the testimony but I would like to add a few things that were not covered.

My job this year, like yours, is going around listening to troubles. But I am listening to physicians' and nurses' troubles. And believe me, if you want to hear malpractice horror stories, I have got them for you. But you have heard them here, and I will not have to repeat those things.

I came earlier, I came here yesterday, and I decided to walk over here to St. John's and talk to some students, medical students that are practicing here. And I asked them, why are they in the profession? And give me a little background.

Well, there are very few considering the high risk specialties of obstetrics, orthopedics, and neurosurgeons. They are not going to practice in places like New York or Florida that are basket cases of malpractice problems. Illinois is rapidly becoming one because of the stories you have heard.

Many doctors are leaving, as Dr. Singleton said. They are leaving practice in their fifties, when they have another 5, 10, 15 years of good practice ahead of them. Doctors know that things can happen, that accidents happen, and we all carry malpractice insurance for that reason. But as they have reiterated, the noneconomic awards, some millions of dollars, destroy the projections of insurance companies in signing up malpractice.

It is not a good business. There are very few companies in Illinois that are selling malpractice insurance. It is not a land office business. It is difficult to get ahold of. People do not make it available.

You know, many people speak, when you are sick or pregnant and you have to go through the system of having the baby in the hospital and paying, that these are doctors' bills, so-called doctors' bills. Of course, then, it is also diagnostic work: the ultrasound, the MRI, diagnostic imaging, this vast technology which is extremely expensive. And everybody expects, whether you are on Public Aid or private pay, you want the best care. And that costs a lot of money.

It is not the doctor's bill. A good part of that doctor's bill is the lawyer's bill. Every pregnancy that some of these people deliver, $300 or $400 of that fee goes for a malpractice premium which is the lawyer's bill, or tort bill, or the court bill. And that is part of the problem. It is not easy to address, it is not easy to solve.

We have 4 percent of the world's population and 70 percent of the lawyers, and there is a problem there.

Not only doctors are limiting their practice but hospital OB departments are closing. You cannot go there and have your baby. They do not have a department for it. There are four in southern Illinois in the region that Cindy Fraed practices in that have closed

their OB departments. So you just go another 10, 20, 30 miles. Hospitals lose money on OB. A hospital is a deep pocket too, because it has millions of dollars of malpractice insurance coverage.

Same injury. One of your people run into somebody or someone in your car breaks a leg or gets hurt and you have minimum insurance, well, the whiplash does not pay as well as the medical negligence suit anymore.

We also have an education problem. We have all quoted the prenatal, perinatal problems of inadequate care, poor education, teenagers becoming pregnant because of inadequate sex education, the AIDS exposure that is coming along. The next group of people to be involved in the AIDS mess are going to be teenagers, because of the promiscuity that is found in the group, and our society has been addressing this particularly this year. And if you think that a child born and handled in a perinatal or a high risk, high aid, natal ward like you have here at St. John's, $14,000 to $20,000, for a teenager who comes down with AIDS in his early twenties, it is going to be $50,000 to $100,000 to take care of. So we do have an education problem here which is also not easy to address.

Money. We need monies for Medicaid programs. Governor Thompson showed us all that if we wanted to make life adequate in this State we had to raise some money this past year. Well, the tax increase was bypassed. The legislature had 60 bills on AIDS. Seventeen of them landed on the Governor's desk for his passage or amendatory veto, but no money attached to it; no fiscal note on how to pay for those AIDS bills. So you have that draining at the State.

In summary, we need some relief on Medicaid reimbursement, but remember, a good part of that is going to be lawyers' bills. We need some tort reform for noneconomic loss, which goes for pain and suffering. If you can convince a jury that it is only insurance company money, the jury is going to lay out a few million: $5 million, $10 million, which can decimate a doctor's practice, certainly, who has that. But a hospital too. A hospital will give up the ghost, and they are.

And we must educate these teenagers. We have to get the message across. Perhaps if somebody does not go to the doctor and presents in emergency room in labor, that person should be made, just like a drunk driver, to get taught and pass a test before she can get pregnant again and do the same thing. Perhaps there should be some kind of responsibility placed on these people as well.

And of course we have to ensure that these people have healthy babies because that is a drain on society as well.

The media owes us this. I mean, the media has sold lean pork, it has sold skim milk, it has sold fitness to the American people. Perhaps they can sell responsibility to teenagers in sexual matters and in early pregnancy or unwanted pregnancy. So there are things that can be done.

While I have sort of digressed from my testimony, I hope it has been helpful to you. Thank you.

[Prepared statement of Edward J. Fesco M.D., follows:]

## Prepared Statement of Edward J. Fesco, M.D., President, Illinois State Medical Society, LaSalle, IL

My name is Edward J. Fesco. I am a board-certified general surgeon from LaSalle, Illinois. I am honored to represent the Illinois State Medical Society in this hearing. And I am pleased to see my own congressional representative, Dennis Hastert, here today to discuss quality of care for indigent prospective mothers and their babies here in Illinois.

Today, I am going to highlight a few reasons behind the stubborn status quo in Illinois' infant mortality rate. We've been struggling to reduce it -- through such valuable programs as the Illinois Hospital Perinatal Network and Parents Too Soon. Yet, circumstances are working against us every step of the way. Circumstances such as Illinois Medicaid reimbursement levels; such as the explosion in teen sex and pregnancy; such as Illinois' ranking in the top five high-cost states for medical malpractice according to the GAO.

First, and perhaps most obviously a root of the problem, is the absurdly low reimbursement levels which obstetricians are paid for treating Medicaid

patients. At only $440 reimbursement for total nine-month care of mother and delivery of newborn, it's a wonder that any physicians are able to take care of Medicaid patients -- and economically survive. It is not a question of physicians not making a sufficient profit, but of being able to keep the medical practice doors open. Obstetricians I've known have reluctantly given up Medicaid deliveries -- because they can't pay expenses, employees and malpractice insurance premiums with a heavy Medicaid patient mix.

As some doctors leave obstetrics altogether, or limit Medicaid patient care, the burden increases on their colleagues. That pressure -- larger and larger volumes of Medicaid patients placed on fewer and fewer physicians -- causes more "drop outs."

In other words, the current reimbursement is not an incentive, but a disincentive for Illinois doctors to treat Medicaid patients. Let me cite just one example: in the city of Baltimore, one insurance company considered making OB/GYNS pay $520 in mecical malpractice coverage for <u>each</u> delivery. Maryland is not a high-cost leader, like Illinois, in medical malpractice. At that 'per delivery' rate, Illinois' Medicaid reimbursement would not cover the cost of insurance, without even considering other expenses. The Illinois disincentive, as you can see, is significant.

A second circumstance working against us is teen sex and early pregnancy. In Illinois during 1985, the infant mortality rate was 11.6 deaths for every 1,000 live births. For teens, the rate was 17.3.

Let's look at, for example, the teen pregnancy rate in southernmost Illinois -- coincidently where the most acute shortage of obstetrical care seems to exist right now. It runs approximately 25 percent in several southern counties, as opposed to an overall average of 12.5 percent in the remainder of Illinois (including Cook County).

There is a much higher medical complication rate in teen pregnancies for all the obvious reasons: less prenatal care, inferior nourishment and the age factor of the mother herself. The Illinois statistics tell a dismal story: just where teens need health care access most is the place they will be least able to find it.

So what can we do about the problems of teen sexuality and pregnancy? For starters, we can encourage teenage mothers to continue their education or to enroll in job training programs so that they can become self-sufficient. And we should pay more attention to teen fathers who must be made to accept their responsibilities in this area.

But these efforts will only address the symptoms of the problem. They won't get at the root causes. The ultimate answer lies with the individual teenager herself ... and himself ... and with their families. As parents, it is our responsibility to help our children come to grips with decisions that they will face with respect to sex ... decisions that can change their lives forever. As community leaders, it is our duty to help teens who don't have strong family support find ways to see beyond the confines of their current situation.

Naturally, the preferable alternative is abstinence. Most young people simply are not ready to handle being sexually active at the same time they're contending with the other trials and tribulations of growing up.

Unfortunately, the "just say no" approach may not be enough. We must remember that, after nourishment and sleep, we're dealing with the human body's third most powerful drive. And where teenagers are concerned, there's still another force at work: the need to conform.

As a physician who must concern himself with public health issues, I'm afraid the battle against teenage sexuality is growing bigger and bigger. For us, the front-line struggle is now pregnancy and AIDS prevention. AIDS is a fatal disease. So far, prevention is the only effective strategy against it.

Within this framework, we must re-evaluate sex education curriculum within our schools. Proper sex education must be afforded our youth early enough to make a difference. Approximately half of all teenaged pregnancies happen within six months of the first encounter.

In some communities, opposition to sexual education rages on. Critics claim that sex education is a matter between parents and their children and that school sexual education classes only encourage young people to become sexually active.

But a 1985 survey sponsored by the American College of Obstetricians and Gynecologists found overwhelming support for school-based sex education. Some 85 percent of the people responding said it should be part of the curriculum.

It's interesting to note that no study has ever supported the view that sex education has any effect on students' level of sexual activity. On the contrary, recent studies have indicated that sex education classes, sometimes combined with school-based clinics, have actually proven effective in delaying the onset of sexual activity and lowering pregnancy rates.

The Illinois State Medical Society supports local school-based health and sex education as an important preventive measure. Local physicians should become

involved. Community input and direction is very important. But we believe that sex education -- early and complete -- is a large part of the answer. By "complete," I mean dealing with the choices and consequences of sexual activity and drug abuse for teens -- one of which is AIDS. Sex education should be aimed at fostering abstinence first, and safety always.

The third circumstance battling healthier mothers and children in Illinois is one to which I've already alluded. It is Illinois' medical malpractice climate. Our 'lawsuit-happy' society is forcing high-risk doctors such as obstetricians, neurosurgeons and orthopedic surgeons to either leave the profession, the state or limit their practices.

Family physicians used to deliver babies; but not many do anymore. This is especially critical downstate, where rural communities in the past depended on family doctors to deliver the community's babies -- because the population was not large enough to support a full-fledged obstetrician. The reason that family doctors don't any longer do deliveries is simple: medical malpractice premiums are boosted 'sky high' when these doctors take on the high risks of obstetrical care. They can't afford to deliver the community's 40 to 50 babies annually and meet stiff malpractice premiums. Family practice physicians are leaving deliveries to specialists, but the specialists aren't there to take them on.

Illinois' physician-owned company, the Illinois State Medical Inter-Insurance Exchange, charges family practice physicians in southern Illinois $5,200 annually for medical malpractice insurance. If they deliver babies, that rate can range up to $26,000. This is for $1 million policy limits.

I'd like to close by talking a bit about the survey our organization conducted earlier this year. We asked our members -- of all specialties, including OB/GYN -- about the impact of litigation on their medical practices. We heard from about 300 OBs -- comprising approximately 10 percent of our sample. They told us they were, in many instances, quitting the practice of medicine, leaving the state, or restricting the type of patients they saw. But they are not alone; other doctors -- both high and low risk -- are following suit for fear of medical malpractice litigation.

For instance, among high-risk physicians (a classification which included obstetricians) were the following results:

-- 84% have ordered additional tests and procedures

-- 78% have made more referrals to specialists

-- 54% have stopped doing certain procedures

-- 4% have moved the location of their practice

-- 68% have become more selective about treating certain patients

-- 6% have retired altogether

-- 42% have limited their use of newly developed techniques

What needs to be done?

In a nutshell, tort reform and better Medicaid reimbursement are keys to improving Illinois' infant mortality results. Tort reform in Illinois means a $250,000 cap on noneconomic damages -- unmeasurable, emotional elements of damage awards which can swing widely from case to case. Better Medicaid reimbursement means giving doctors at least a 'break even' proposition, if not an incentive to take on many medically complex pregnancy cases.

A word about Medicaid benefit eligibility: expanding benefits to new groups of prospective mothers will further exacerbate the problem. Without adequate physician reimbursement, expansion of Medicaid benefits will drive more and more doctors away from treating Medicaid patients.

Everyone at this hearing is, in some manner, committed to reducing infant mortality. Over the long term, we must work hard to educate our adolescents on sex, and prevent teen pregnancy. This will not be easy. The Medical Society is working hard to promote teen sex education as a means of halting the spread of AIDS. But short-term relief rests on policymakers such as

yourselves taking strong steps to provide adequate Medicaid resources and to reform the malpractice liability climate. Just mouthing the words, "we must reduce infant mortality," won't work.

In short, our commitment to all the areas noted above -- both short term and long term -- must not waiver, if our goal is healthier mothers and healthier children for the future of Illinois.

Thank you very much.

Chairman MILLER. Thank you. Ms. Dunn.

**STATEMENT OF BARBARA BURKE DUNN, EXECUTIVE DIRECTOR, COMMUNITY HEALTH IMPROVEMENT CENTER, DECATUR, IL**

Ms. DUNN. Mr. Miller and members of the committee, thank you for allowing me to come here today and testify. And I am sure you will be ready to heave a sigh of relief since I am the last one.

My name is Barbara Dunn. I am the director of the Community Health Improvement Center in Decatur. The Center provides primary medical care for 5,000 to 6,000 low income infants, children, and adults residing in Macon County.

About 70 percent of the people that we see are already on Illinois Public Aid. About 10 percent are Medicare eligible and the remainder are self-payers on a sliding fee scale. We have a few, maybe 1 or 2 percent, that have some kind of health insurance. Generally speaking it is catastrophic insurance. Therefore we realize very few dollars from that particular method of payment.

Unlike a number of community health centers we do not provide on-site obstetrical care. A major reason for this is that we do not have a physician who has the capability to do the delivery and obstetrical care. However, we do provide pregnancy testing, referral to the two prenatal clinics in Decatur, family planning, and care for sick and well children including immunizations.

We also have a large health education component. One of the things we have been doing lately is working at the area vocational center in Decatur, in their pregnant student class and their young mother class, doing prenatal and postnatal education with a heavy emphasis on developmental things with the baby, good health care for both mother and infant.

Macon County is a county of approximately 128,000 people. It is located in central Illinois. Decatur, a city of 94,000, has been severely affected by the economic downturn in the early 1980's. At one time the unemployment was one of the highest in the nation. Currently, 9.1 percent of the population is unemployed. This is significantly higher than the 6.8 statewide average or the 5.8 national average.

In August 1987, in excess of 13,000 people were receiving some kind of public assistance and 42 percent of the elementary students in our public school district are eligible for either a free or subsidized hot lunch.

Manufacturing jobs, which were once the mainstay of the economy of our county, have fallen from a high in 1980 of 19,600, to the current level of 13,500. In 1985 Macon County was one of the counties designated by the Governor's infant mortality reduction initiative. And since then we have been able to put into place a number of health care services that were already there, but we have built up a very strong network of health care services which complement the two prenatal clinics which we have in each of our hospitals.

Currently infant mortality in Macon County is 13.6 per 100,000. The State rate is 12. Amongst black infants this number is closer to 22 per 100,000; 16.3 percent of the births are to teenagers; the state rate is 12.5 percent; 6.7 percent of the women who delivered babies

in Macon County in 1986 had no prenatal care or began care in the third trimester. This figure contrasts with the State level of 4.6 percent.

Needless to say, these are alarming figures. What in the opinion of many is even more troublesome is that locally we do have a good network of services, locally we do have prenatal clinics, we do have in place the Illinois Department of Public Aid's initiative called the Healthy Kids Initiative, which provides outreach and case management services for children who are Public Aid-eligible.

So we have tried to look a little deeper into what some of the problems might be. Many women in Decatur for reasons of pride, embarrassment, or misconceptions about quality of care, do not access prenatal clinics. This same thing can be said for women across the State.

In parts of the State women do not have the opportunity to utilize a clinic setting, or they fear—particularly in the Chicago area—becoming a faceless number in an enormous waiting room. Young teens and working poor are probably the most overwhelmed by a system with which they have little or no experience.

Loss of jobs has also meant, locally and statewide, loss of insurance benefits. While the employment picture in Decatur has improved considerably in the last 18 months most employment gains have been in the traditionally lower paying service sector. Many of these jobs are less than fulltime and there are no benefits that go along with it. The cost of private insurance is prohibitive. Premiums in excess of $150 a month are not unusual. It is unimaginable for a family where their income is perhaps $10,000 a year, which would be $5 an hour income, they cannot afford any kind of insurance.

The Medicaid Program, as we have already discussed, is a federally mandated program. However, the income guidelines to determine eligibility are set by the states. In Illinois, as a general rule, an individual must have an income of close to one-half the poverty level before he or she can qualify for benefits. Frequently expenses that are incurred in the hospital—we talked earlier about spenddown. When the actual hospitalization occurs, then the Medicaid program will kick in. It does not kick in for the very crucial prenatal visits and it stops once the mother and child are out of the hospital and she goes to seek well-child medical attention for her children.

In the recent legislative session there was some agreement that the eligibility benefits would be extended to encompass all women who are at or below the poverty level for prenatal care, as well as for well-child care for children up to the age of one year. However, the down side of that particular piece of legislation is that there is not going to be any move on this, probably, for about a year.

Much publicity has been given to the so-called physician glut. I do not think we pick up a newspaper but we do not read about the huge number of physicians. While there may be a surplus number of physicians in affluent areas, there continues to be a serious physician shortage in rural and in urban disadvantaged areas.

The Community Health Center in Decatur, and for that matter, community health centers across this country, could not exist without physicians from the National Health Service Corps. A physi-

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cian can see a finite number of patients, and generally is less likely to accept Public Aid or medically indigent patients, particularly women who are at high risk because of another condition.

Many physicians in our area categorically refuse to see patients on Public Aid. All women are expected to go to the clinics. They are not seen as private patients, except in unusual exceptions. They have no choice in this particular matter. One statistic that was mentioned earlier is that Springfield has 22 obstetricians. Decatur has 10. We are a city of roughly the same size.

The reasons for the much debated malpractice question have been brought out, I think. One thing I would add is that frequently when you get the envelope with the increase in malpractice insurance there is no reason stated by the insurance company; none whatsoever. And any phone call to them results in essentially no answer.

Lack of insurance, ready cash, or inability to find a physician who will accept a medical card are also considerations in determining what type of health care a child receives after birth. Many health departments including the Macon County Health Department provide free well-child care and immunizations. However, sick children are a different issue.

For all practical purposes our health center is the only place a poor child can receive medical care in our county. Fortunately we have a full-time pediatrician who is kept extremely busy, I might add.

In the early years of life it is essential that children receive ongoing medical care. Growth and development must be monitored, immunizations given, and followup for acute and chronic problems has to be provided. When parents cannot afford these services for their children, small, easily solved difficulties can become major problems. Haphazard medical care can also mean that developmental delays or cases of abuse and neglect are overlooked or ignored.

Awareness or public perception seems to play a major role in the problem of infant mortality. In the early part of the century maternal and infant deaths were commonplace. As statistics improved there was less concern about the problem. Terminology has changed. We speak about negative outcomes or significant anomalies. We do not talk about babies who are born who will never lead a full and productive life, or babies who die.

The correlation of excessive drinking, smoking, and drug usage in problem pregnancies cannot be stressed enough to women of childbearing age. And this type of education must be given before conception. It must be ongoing and consistent. It is not enough to do a once-a-year media blitz about the problem and then just be quiet the rest of the year.

Among some populations the value of good prenatal care is not appreciated or understood. Many women are children and grandchildren of traditionally unserved and/or underserved populations who had little or no prenatal care themselves. Furthermore, these women themselves were frequently medically neglected as children. What then was good enough for the mother now becomes good enough for the daughter.

Obviously considerably more effort will have to be expended into the educational aspects of this problem. The efforts will be costly

and their effects initially will be difficult to measure or monitor. The target population of low income, minority, migrant, and non-English-speaking women is not easy to reach.

Federally funded community health centers have proved to be the medical safety net for many of this nation's poor in many areas of the country. Many centers have creatively utilized Federal, state and local, public and private funds to provide quality medical care, health promotion activities and case management services in a cost-effective manner.

The solution to the problem of infant mortality will not come cheaply. On the other hand no child should ever die or be born disabled because his or her mother was not aware of the need for good prenatal care. No child should ever die, or be left permanently physically or mentally incapacitated because his or her parent could not afford medical care. No parent should ever be forced to consider delaying needed medical care, prenatally or postnatally, because of cost. I can assure you that such decisions are made daily. Thank you.

[Prepared statement of Barbara Burke Dunn:]

## Prepared Statement of Barbara Burke Dunn, Director of the Community Health Improvement Center, Decatur, IL

My name is Barbara Dunn. I am the Director of the Community Health Improvement Center in Decatur, Illinois. The Center provides primary medical care for 5,000-6,000 low income infants, children, and adults residing in Macon County. Approximately 70 percent of our patients are Illinois Public Aid recepients: 10 percent are Medicare eligible and the remainder are self-payors. Few, less than 2 percent, have any type of health insurance. The self-payors are charged on a sliding fee schedule based on Federal Poverty Income Guidelines. About 85 percent of our self-pay patients qualify for the lowest fee level - their incomes are at or below poverty level. Unlike a number of community health centers nationwide, our Center does not provide onsite obstetrical care. However, we do provide pregnancy testing, referral to prenatal clinics, family planning and care for well and sick infants, including immunizations.

Macon County, with a population of approximately 128,000 persons, is located in Central Illinois in the heart of some of the richest farmland in the United States. Decatur is an industrial city of 94,000, severely affected by the economic downturn of the early 1980's. At one time the unemployment rate was one of the highest in the nation. Currently 9.1 percent of the population is unemployed, significantly higher than the 6.8 percent statewide average or the 5.8 percent national figure. In August 1987, in excess of 13,000 persons were receiving some type of public assistance. Manufacturing jobs, once the major source of income for many in the community, have fallen from 19,600 in 1980 to the current level of 13,500. 42 percent of the children enrolled in the Decatur elementary schools qualify for reduced or free hot lunches.

Over the last several years the problem of infant mortality has received increasing state and federal attention. In 1985, Macon County was one of several downstate counties targeted in the Governor's Infant Mortality Reduction Initiative, (now, known as Families With A Future). 1986 statistics for Macon County mirror those of many inner city urban areas as well as remote rural areas of our country:

> The infant mortality rate was 13.6/100,000 vs. a state rate of 12.0 - amongst black infants the figure was closer to 22/100,000.
>
> 16.3 percent of the births were to teens, compared to the state figure of 12.5 percent.
>
> 6.7 percent of the women who delivered babies in Macon County in 1986 had no prenatal care or began care in the third trimester of pregnancy. This figure contrasts with an overall state rate of 4.6 percent.

These figures are alarming in and of themselves. What, in my opinion, and that of other professionals in the community makes these statistics even more troublesome is that, locally, there are two prenatal clinics - one at each hospital, and a network of health care and social services targeted to the low income high risk population. Many women in the Decatur area for reasons of pride, embarassment, or misconceptions about quality of care do not access the prenatal clinics

until late in their pregnancies. In parts of the state, women either don't have the opportunity to utilize a Clinic setting or fear becoming a faceless number in a huge waiting room. Young teens and the working poor are probably the ones most overwhelmed by a system with which they have had little or no experience.

We have concluded that most of the factors which influence infant mortality rates in similarly disadvantaged areas are also the major causes of problems faced in Decatur. Two issues seem to stand out: economics and awareness or public perception.

Loss of jobs has also meant loss of insurance benefits. While the employment picture in Decatur has improved considerably in the last 18 months, most employment gains have been in the traditionally lower paying service sector. Many of these jobs are less than full time and offer no benefits. The cost of private insurance is prohibitive. Premiums in excess of $150.00 per month are not unusual. Simply put, an individual earning even as much as $5.00 per hour can not afford insurance.

The Medicaid program is federally mandated, but income guidelines to determine eligibility are determined by the states themselves. In Illinois, an individual must have an income close to one-half the amount designated as "poverty level" before qualifying for benefits. Frequently, expenses incurred in the hospital for actual delivery and newborn care are high enough to be covered by Public Aid. Yet, critical care for mother and child, prenatally and postnatally will not be covered.

Much publicity has been given to the so called physician "glut". While there may be a surplus number of doctors in affluent urban areas of the country, there continues to be a serious physician shortage in rural and disadvantaged areas. The Community Health Center in Decatur and, for that matter, community health centers across the state could not exist without physicians from the National Health Service Corps. A physician can see a finite number of patients and, generally is less likely to accept Public Aid or medically indigent patients, particularly high risk women. Many physicians in our area catagorically refuse to see persons on Public Aid. All poor women are expected to be "clinic" patients. They have virtually no choice in the matter.

The reasons for the much debated malpractice crisis are not at issue here. However, the fact is that physician malpractice insurance has increased dramatically in the last several years. The rates for those doctors with obstetrical practices have become so astronomical that many family practice physicians have given up the obstetrical portion of their practice. This decision on their parts has had an enormous negative impact, particularly in rural areas, but has also greatly limited access to prenatal care in some urban areas as well.

Lack of insurance, ready cash, or inability to find a physician who will accept a medical card are also considerations in determining what type of health care a child receives after birth. Many health departments, including that in Macon County, provide free well child care and immunizations. However, sick children are another issue. For all practical purposes, the Community Health Improvement Center is the only place a poor child can receive medical care. Fortunately, the Center has a full time pediatrician on staff. Emergency rooms are inundated with persons seeking care for their children. In the early years of life, it is essential that children received ongoing medical care; growth and development must be monitored; immunizations given; follow-up for acute and chronic problems provided. When parents

cannot afford these services for their children, small easily solved difficulties can become major problems. Haphazard medical care can also mean that developmental delays, or cases of abuse and neglect are overlooked or ignored.

Awareness or public perception seemed to play a major role in the problem of infant mortality. In the early part of the century, maternal and infant deaths were commonplace. As statistics improved, there was less concern about the problem. Terminology changed. We speak of "negative outcomes", "significant anomolies" not about babies who are severely physically or mentally handicapped, or infants who die. The correlation of excessive drinking, smoking, and drug usage and problem pregnancies cannot be stressed enough to women of child bearing age. And, this type of education must be given before conception, be ongoing, and consistent. It is insufficient to have an annual media blitz on these issues. Amongst some populations, the value of good prenatal care is not appreciated or understood. Many women are children and grandchildren of traditionally unserved or/and underserved populations who had little or no prenatal care. Furthermore, these women themselves were frequently medically neglected, as children. What was "good enough" for the mother now becomes "good enough" for the daughter.

Obviously, considerably more efforts will have to be expended into the educational aspect of this problem. These efforts will be costly and their effects, initially, will be difficult to measure or monitor. The target population of low income, minority, migrant, and non-English speaking women is not easy to reach. Federally funded community health centers have proven to be the medical safety net for many of this nation's poor. Many centers have creatively utilized federal, state and local public and private funds to provide quality medical care, health promotion activities, and case management services in a cost efficient manner.

The solution to the problem of infant mortality will not come cheaply. On the other hand, no child should ever die or be born disabled because his or her mother was not aware of the need for good prenatal care. No child should ever die or be left permanently physically or mentally incapacitated because his or her parent could not afford adequate medical care. No parent should ever be forced to consider delaying needed medical treatment, prenatally or postnatally, because of cost. I can assure you that such decisions are made daily by countless parents.

Chairman MILLER. Thank you. Congressman Durbin.

Mr. DURBIN. Barb Dunn, you mentoned the National Health Service Corps, and I think Ms. Eisenstein also uses National Health Service Corps physicians. Over the last 5 or 6 years this has been a program which Congress has been asked to virtually abolish because of our needs to cut back in spending to reduce the budget deficit. What would be the net impact if in fact CHIP or your program, Ms. Eisenstein, had no National Health Service Corps physician available?

Ms. EISENSTEIN. I think, in our program without those physicians—they just began providing services just this last August, so we went for a year before that without them. Every single woman in the counties of Alexander and Pulaski had to be driven to the Carbondale area for prenatal care. So it has a great impact upon the grant funds in that we have to use a significant portion of that for transportation. And then you have these women who are driving so far for prenatal care, especially in the latter stages of pregnancy. I feel that it is unacceptable.

Mr. DURBIN. Fine.

Ms. DUNN. I think that if the National Health Service Corps is not funded in some manner it will be catastrophic for the poor of this nation.

Mr. DURBIN. Dr. Fesco, during the last session of the Illinois General Assembly—or the previous session; I am not sure which—there were some malpractice reform bills passed and signed by the Governor. One of them required that, if a poor plaintiff would file a malpractice suit in Illinois, they had to present an affidavit from a doctor that they had a serious claim.

Now, it is my understanding—and I wish you would elaborate—that this has resulted in a net decrease of malpractice claims against most specialties but not in the area of obstetrical care. Could you comment on this?

Dr. FESCO. Well, there were significant reforms that came out of the legislative session, the one you mentioned as well as the decrease in statute of limitations. Before that a baby grown to 22 could sue the obstetrician that delivered him for some wrong, real or imagined, for 22 years. The statute of limitations did not apply. That was reduced to eight. That was significant and allows insurance companies to project some future spending.

The reform where you get a doctor to comment and say, yes, there has been negligence and this is a worthwhile suit, this is in fact—although in other states it has been thrown out as unconstitutional, but it is currently still the law here, and it has decreased the number of suits, and this is, of course, looked forward to.

But as far as the lady mentioned that with the insurance premium increase there was no excuse, there are fewer and fewer companies in business. St. Paul, that was mentioned by one of the participants, has just left Florida because the state decided one way to cut down malpractice premium rates was to prevent the insurance company from charging more. Well, St. Paul said goodbye, and left 5,000 doctors without malpractice insurance, any malpractice insurance in Florida. So that is not quite the answer either.

Mr. DURBIN. Doctor, if I could ask one last question, Dr. Singleton came by my office a couple of months ago and really spelled

out in graphic terms what local obstetricians are facing with malpractice premium increases. The ones that have been cited in testimony today I think, without exception, have cited the increases of the St. Paul Insurance Company, where premium costs went from $36,000 a year to $47,000 for 6 months.

Now, the Illinois State Medical Society has its own malpractice insurance pool for its members. What are the comparable premiums that are being charged obstetricians through the Illinois State Medical Society?

Dr. FESCO. Between $20,000 and $35,000.

Mr. DURBIN. So the amount being charged by St. Paul is more than twice the amount charged by the Illinois State Medical Society?

Dr. FESCO. Well, they came in and drummed up some business by offering what we felt might be low premiums. But I am just a doctor, I am not an insurance adjuster, and I hesitate to get into the reasons why these things happen. But there are not too many companies selling malpractice insurance in Illinois. The doctors got together seven years ago. Everybody chipped in some thousands of dollars and said, let us start our own company.

Mr. DURBIN. It is a not-for-profit operation, is it not?

Dr. FESCO. Not for profit. It is a risk management thing.

Mr. DURBIN. Your premium is about $25,000 a year for obstetricians as opposed to——

Dr. FESCO. Well, in certain segments of the State. Some parts of the State——

Mr. DURBIN. How about downstate in Springfield?

Dr. FESCO. That is a little less. That is less. In Chicago there are obstetricians paying $140,000 for the——

Mr. DURBIN. To the State Medical Society?

Dr. FESCO. Not the State Medical Society. It is still cheaper.

Mr. DURBIN. Well, I might add in defense of Dr. Singleton, I know that there is a considerable expense in transfer, that costs a physician $100,000 to move from St. Paul Insurance Co., to the State Medical Society; something in that neighborhood. The long tail of liabilities has to be covered there.

Thank you very much. I might add that one of the things we are considering in Washington is some type of risk pool that might be available, at least on a demonstration basis, to see if we can find a way to help the doctors provide the medical care and not run this high risk of malpractice premiums and liability. Thank you.

CHAIRMAN MILLER. Thank you. Mr. Hastert.

Mr. HASTERT. Thank you, Mr. Chairman. Ms. Eisenstein, one of the things that really amazed me in your testimony was that you have had 445, I believe, participants in the program in the last year, and zero deaths. Is that correct?

Ms. EISENSTEIN. We have had 424 births since we began programming, which was I think about January of 1984, and we have had zero deaths.

Mr. HASTERT. And you also gave testimony that the Parents Too Soon Program that you are part of, is really part of the Department of Children and Family Services. Is that correct? Do you coordinate then with the Department of Public Aid and Public Health?

Ms. EISENSTEIN. We receive funding through the Department of Public Health, Parents Too Soon. We are a demonstration project. And then we also receive funding through the Ounce of Prevention Fund. Their funding comes from the Department of Children and Family Services, but all of our sources of funding are part of the statewise Parents Too Soon initiative.

Mr. HASTERT. Correct. One last question, then, for you. Is that—you have had 445 participants, I believe? That was close to the figure at least.

Ms. EISENSTEIN. Yes, pretty close.

Mr. HASTERT. How is your outreach? You are in a rural area and I am sure you have a lot of small high schools. How do you get to the people?

Ms. EISENSTEIN. The outreach efforts are tremendous. I worked as a home visitor in one of our programs for 2½ years before I was the Administrator, and in 2 years I put 83,000 miles on my car. So that is probably the best example I can give of our outreach efforts.

Mr. HASTERT. I understand that Dr. Fesco, you say that the high cost of malpractice insurance for a physician could cost between $200 and $300 per case that you take. Then I think in your testimony you also tried to say that because of high risk for a doctor who takes prenatal and gyniatrics is at risk of even having a greater risk of being sued. So that you take extra procedures that are more expensive? Is that what you are trying to say? Did you say that?

Dr. FESCO. Yes. One of the problems with the malpractice climate is that you cannot practice medicine sensibly. You have to go overboard and order literally everything. It is very difficult to explain to a lawyer during a courtroom trial that takes five years to come to the court, why you did not order something that just might have changed the outcome. And it is very difficult, as Dr. Fraed mentioned; it is very hard to say why.

Mr. HASTERT. So this is really kind of a Monday morning quarterbacking thing here.

Dr. FESCO. Or a new technology. It is very hard for the jury to move itself back many years as to what was available at that time when we have new advances constantly.

Mr. HASTERT. State of the art. Then, also, in your role as President of the Illinois Medical Society, you represent all types of doctors who have medical practices, we talk about need for increased funding in this particular area. But certainly people who are in geriatrics or people who are taking pediatrics, there is need there for increases too, so there is really a competition here for these dollars that are in the pipeline, is that correct?

Dr. FESCO. There is never enough money for people's expectations, as you as a Congressman surely know.

Mr. HASTERT. Well, we are learning. I appreciate it. And do you feel that—you know, we have talked about the State pools and different types of insurance opportunities—that, in your feeling, if there was significant reform in Illinois, that the costs of medical service to those people who need help, the working poor and beyond that, would be improved?

Dr. FESCO. I think that would be a large part of the problem. It would help solve this huge balloon of uncertainty as to what can possibly happen.

Every doctor wants to have malpractice insurance. When I become a patient I want to go to a doctor that has malpractice insurance, because an accident may happen. But it is the multi-hundred-thousand and million-dollar awards that are dangerous.

There are two students at SIU, medical students, that are named in malpractice suits because their names appeared on the chart. Now, what a way to start a career.

Mr. HASTERT. Thank you, And thank you, Mr. Chairman.

CHAIRMAN MILLER. Thank you. And on behalf of the committee let me thank you for your time and your testimony and your effort to be with us this morning.

And finally, let me again thank the administration and Staff here at St. John's Hospital for helping us to put on this hearing. And I guess we recess here until we go to Chicago this afternoon. Thank you very much.

[Whereupon, at 11:55 a.m., the committee recessed to reconvene in the afternoon in Chicago.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF JAMES L. DIEKROEGER, DIRECTOR OF PUBLIC HEALTH, SPRINGFIELD DEPARTMENT OF PUBLIC HEALTH, SPRINGFIELD, IL

The Springfield Department of Public Health is a certified city health department providing a broad range of services to residents of Capital Township as well as limited services to residents residing in Sangamon County but outside of Capital Township.

This agency receives funding from the corporate tax fund, federal and state grants, and fees.

Since 1983 this agency has received state funding to purchase prenatal care for eligible clients. The first two years of funding were limited to pregnant females ages twenty (20) and under who did not have a medical card (or was not covered by a parent's medical card), had no medical insurance coverage, or did not qualify for a medical card, and were otherwise financially indigent. At least eight-five percent of our funding is for direct care services. Beginning with the 1985-86 grant year we were allowed to extend the services to any pregnant female who is/was financially indigent, did not have a medical, or was ineligible for a medical card.

Each year that we have been funded, a letter is mailed to every practicing obstetrician in Sangamon County advising them of the grant and requesting their participation.

The physicians are advised that they will be reimbursed for providing prenatal care, delivery, and the post partum check at the current Public Aid reimbursement rates. If the client is approved for Public Aid during the course of her pregnancy, the physician is advised that Public Aid will be responsible for reimbursement.

The grant also allows the Springfield Department of Public Health to provide funding for limited specified laboratory tests as well as prenatal vitamins and certain other allowable drugs.

Each year the number of participating obstetricians/offices has dwindled from nine physicians, five offices in fiscal year 1983-84 to four physicians, three offices in fiscal year 1987-88.

The physician reimbursement in fiscal year 1983-84 was $375.00 for a vaginal delivery. Fiscal year 1987-88 reimbursement is $446.50 for a vaginal delivery. Reimbursement for a Cesarian section in 1983-84 was $438.00 and $521.50 in 1987-88.

A client presented to this agency for financial assistance must also apply for a medical card and then bring proof of approval, denial, or spend down to this agency. Applying for Public Aid is a humiliating and discouraging process. One need only accompany a client to an appointment to fully appreciate the trauma.

I will not belabor the problems of low reimbursement, extended turn around time for Public Aid reimbursement, and the tremendous increase in malpractice premiums in as much as these problems were addressed factually by Dr. Cynthia Fraed and Dr. James Singleton.

Since the Springfield Department of Public Health Prenatal and W.I.C. grants are state and federally funded, this agency provides these services to eligible residents of Sangamon County.

Referrals are received from local agencies, clients themselves, clients on the program, physicians, and within this agency.

Approximately one third to one half of the clients we enroll in the prenatal program become eligible for a medical card.

The Springfield Department of Public Health provides support services to prenatal clients residing in Sangamon County. Eligible clients are recipients of W.I.C., a staff nurse visits the client during the course of her pregnancy, transportation to doctor's appointments, W.I.C., Public Aid is also available.

Following the birth of the baby, the staff nurse continues to make home visit(s).

This agency also conducts three Child Health Assessment Clinics (Well Child) and four Immunization Clinics weekly. These two clinic services are also available to county residents through state preventive block grant monies.

The Springfield Department of Public Health has three Sexually Transmitted Disease Clinics weekly. Pregnancy testing is available during these clinics as well as one additional morning and afternoon each week.

There is no fee for any of the above mentioned services.

To varying degrees decrease in physician participation to provide prenatal care to these identified clients is evident throughout Illinois and other states in the country.

The Illinois Department of Public Health has funded a prenatal clinic at the Lake County Health Department for several years. I would encourage you to visit and/or

communicate with Dr. Steven Potsic, Administrator and Mary Carter, Nursing Administrator. Enclosed is a copy of the recognition their agency received from Center for Disease Control for implementation of a school based education and support program for pregnant teens and teen parents.

Thank you for the opportunity to present written testimony.

PREPARED STATEMENT OF H. BRENT DE LAND, PH.D., EXECUTIVE DIRECTOR, ILLINOIS COMMUNITY ACTION ASSOCIATION AND ADJUNCT ASSOCIATE PROFESSOR AT SANGAMON STATE UNIVERSITY, SPRINGFIELD, IL

Mister Chairman, Congressman Durbin, members of the committee, staff, ladies and gentlemen, I am most grateful for this opportunity to present testimony on this day dealing with the growing problem of infant mortality. I am H. Brent De Land, Executive Director of the Illinois Community Action Association and Adjunct Associate Professor at Sangamon State University. I hold a doctorate degree in management from the Union Graduate School and have worked in human service programs for the past two decades.

The Association has a small grant under the Community Food and Nutrition Program, Office of Community Services, Department of Health and Human Services and administered by the Illinois Department of Commerce and Community Affairs. As a result of this grant I have become familiar with the unfortunate relationship between infant mortality and nutrition. Specifically, I wish to address the relationship of infant mortality and prenatal nutrition.

To put our concern in proper medical perspective, consider the statistical data. One clear link to infant mortality is low birth weight. Low birth weight is considered a weight of 5 pounds 8 ounces/2500 grams or less, according to the

Institute of Medicine. In Illinois, according to the Illinois Department of Public Health, 71% of all infant deaths were among infants with a low birth weight. In other words, using 1985 statistics, of 1,471 infant deaths, 1,042 infants had birth weights at or under 5 pounds 8 ounces. Although low birth weight has several possible causes, two clear and consistent causes present themselves: teenage mothers and poor or improper prenatal nutrition.

The Committee to Study the Prevention of Low Birthweight of the Institute of Medicine in a 1985 report said, "Low birthweight is a major determinant of infant mortality in the United States. Most infant deaths occur in the first 4 weeks of life, the neonatal period, and most are a consequence of inadequate fetal growth, as indicated by low birthweight . . . Higher neonatal mortality rates seen for non-white mothers, teenage mothers, and mothers of low educational attainment are explained largely by higher proportions of low birthweight infants among these groups." This clearly affirms my prior statement.

Research has shown the risk of low birthweight declines sharply among mothers with at least 12 years of education.

Further, the gap in low birthweight rates among mothers with disparate educational attainment is not closing, but rather, may be widening. Unmarried mothers have a consistently higher rate of low birthweight children.

Again to quote from the report, " Many cross-cultural studies show that women from poorer social classes have infants of smaller birthweight than more affluent women. While socioeconomic status factors other than poor nutrition may play a role in this relationship, restricted diets may be a key component . . . Low birthweight occurred 4 times more frequently among women who gained less than 14 pounds than among those who gained 30 to 35 pounds."

The 1980 National Natality and Fetal Mortality Surveys found that many groups of women known to have an increased risk of delivering a low birthweight infant also were more likely to have inadequate weight gains. For example, they found that black mothers were twice as likely as white mothers to gain less than 16 pounds during pregnancy. Mothers 35 years of age or older and teenage girls were less likely to gain at least 16 pounds, as were unmarried women, poorly educated women, and women of lower socioeconomic status.

The findings of the two reports cited show that poor nutritional status before pregnancy and inadequate nutritional consumption during pregnancy have a clear negative impact on fetal weight gain, thereby increasing the risk of low birthweight.

For a moment allow me to return to statistics to show the relative importance of this question in Illinois and the nation. The downward trend in infant mortality experienced between 1975-1980 showing a 22 percent decrease, has now been reduced to 16 percent since 1980 in the United States. In Illinois, between 1985-1986 infant mortality increased by 3 percent, from 11.6 to 12.0 deaths per 1,000 live births. For white infants, the increase went from 9.1 percent to 9.3 percent and the rate among nonwhite infants grew, increasing from 20.0 percent to 21.0 percent per 1,000 live births. At the same time the U.S. total rate was 10.4 percent per 1,000 live births. Therefore, the Illinois rate was a full 1.6 percent greater than the national average per 1,000 live births.

The disparity between white and nonwhite infant mortality is

related as much or more to poverty than any other factor. Consider a recent statement from the Children's Defense Fund, "Pregnant teens are disproportionately members of racial minority groups, and minority families are disproportionately poor. While black women accounted for 16 percent of all Unites States births in 1982, they accounted for 55 percent of births to women under age 15 and 27 percent of births to women between the ages of 15 and 19. Currently, nearly 50 percent of all black children under the age of 18 live in poverty." Even if pregnant teens were educated to the maximum extent possible about their health needs and about the importance of receiving early and comprehensive prenatal care, thousands would continue to face grave poverty-related barriers in their attempt to obtain health services.

Low birthweight as a contributing factor in infant mortality issues is by far not the extent of this troubling problem. According to the March of Dimes, low birthweight is now considered the most common problem at birth. Low birthweight affects one in every 15 babies born in the United States today. The March of Dimes has concluded that the mothers' habits during pregnancy are the major

contributing factors to low birthweight. Not surprising, the foremost habit contributing to the problem is that of poor nutrition. A fetus eats what the mother eats, and if the mother eats poorly or not at all, the fetus is starved for vital nutrients required for birthweight, proper development, and good health throughout the life of the baby after birth.

This information is by no ways new. The classic study of Bertha S. Burke, et al conducted by the School of Medicine at Harvard University published in 1943 showed the significance of diet and infant health. According to the 1943 study:

> "1. A statistically significant relationship has been shown between the diet of the mother during pregnancy and the condition of her infant at birth and within the first 2 weeks of life.
>
> "2. If the diet of the mother during pregnancy is poor to very poor, she will undoubtedly have an infant whose physical condition will be poor. In the 216 cases considered in this study, all

> stillborn infants, all infants who died within a few days of birth except one, most infants who had marked congenital defects, all premature, and all functionally immature infants were born to mothers whose diets during pregnancy were very inadequate.
>
> "3. If the mother's diet during pregnancy is good or excellent, her infant will in all probability be in good or excellent physical condition. It may, however, happen rarely that a mother whose diet during pregnancy is good or excellent will give birth to an infant in poor physical condition (1 out of 216 cases in this study)."

There should be no question, the poor are most often the victims of low birthweight and infant mortality. An interesting dynamic is, however, present. Often poverty is linked to large urban areas. In Illinois, many of our lawmakers believe the question of poverty related problems is contained within the city limits of Chicago. Relative to infant mortality, this is clearly not the case. According to Illinois Department of Public Health data,

> "Of the thirteen downstate cities with over 1,000 resident live births, three--East St. Louis, Elgin and Joliet--had higher mortality rates than did Chicago in 1986. This marked the fourth consecutive year in which East St. Louis' rate exceeded Chicago's. Five other Illinois cities with populations over 25,000--Chicago Heights, Danville, Harvey, Kankakee and Maywood--had higher rates of infant death than Chicago during at least two of the past three years."

Using St. Clair County as a case example, the infant mortality rate increased 33 percent between 1985 and 1986, from 11.6 to 15.4 deaths under 1 year per 1,000 live births. Further, statistics are less reliable on areas with sparse population and therefore, a correlation in smaller counties present some research difficulties. For example, in Kankakee County, the infant mortality rate is greater than Chicago and the state average, yet we cannot document this in terms of poverty pockets in the county. It is my personal, yet unconfirmed, belief that the problem is greatest among the poor living in Sun River Terrace, Pembroke Township, and in other areas of poverty

concentration. Similarly, in Springfield, I suggest the East and North areas of the city who experience lower income experience lower birthweight and greater infant mortality.

I shall now focus my testimony on two principal factors leading to low birthweight and ultimately fetal/infant mortality, maternal nutrition, both pre-pregnancy and during pregnancy. According to the Institute of medicine,

> ". . . while both nutritional status before pregnancy and nutritional intake during pregnancy influence birthweight, they are not independent. Prepregnancy weight and weight gain during pregnancy are negatively correlated. Substantial prepregnancy weight can compensate for low pregnancy weight gain, and vice versa. A combined deficit appears to be the most detrimental. The existence of these two compensating maternal nutrition systems--prior nutritional storage and nutritional intake--is clearly protective for the developing fetus; it helps guarantee that adequate nutrition will be available. However, it makes analysis of the impact of nutrition on pregnancy

> outcome difficult. Maternal dietary inputs or absences during pregnancy do not translate directly into fetal growth or its retardation. The relationship and trade-offs between these two maternal nutrition systems remain to be fully explored."

Doctors Worthington-Roberts, Vermeersch and Williams in their 1985 book Nutrition in Pregnancy and Lactation define one important community resource for poor women concerned with proper nutrition during pregnancy.

> "Other special projects, such as Women, Infant, and Child Care (WIC), seek to reach underserved or economically depressed areas to provide additional outreach services. These programs have proved to be effective as evidenced by decreased morbidity and mortality of infants and mothers participating in the WIC program. Other community programs stem from various community action groups. Innovative health projects and food advocacy programs have resulted, often reaching out to meet needs outside the mainstream of medical care."

I encourage this committee to look most favorably on increasing this program to a level that will allow all eligible Americans to obtain the vital life supporting services offered by WIC. According to Dr. Worthington-Roberts, et al,

> "A positive outcome of pregnancy is built on positive nutritional support throughout prenatal care. In the light of specific knowledge, false assumptions and negative practices of the past have given way to a positive approach based on demonstrated nutritional needs of both mother and child.
>
> "These increased nutritional requirements during pregnancy are based on age and parity of the mother, her preconception nutritional status, individual needs, and a unique biological synergism. This synergistic whole is based on complex metabolic interactions among the three biological entities involved: maternal organism, fetus, and placenta. All of these factors combine

to create nutritional demands for support of the pregnancy. Thus current positive practices in prenatal care and counseling are built on (1) increased nutritional requirements, (2) normal physiological adjustments of pregnancy, and (3) individual assessment and guidance.

"The increased nutritional requirements of pregnancy include protein for tissue building material, energy (kcal) for the heightened metabolic work involved, and vitamins and minerals for metabolic control agents acting as both cell enzyme partners and construction material.

"To assure that these increased nutritional needs are met, the process of nutrition assessment is fundamental in all prenatal care. This general process includes clinical observations, body measures with attention to good quality weight gain, obtaining significant social and medical history, and monitoring laboratory data. Detailed personal data concerning living situation and food patters provide the basis for supportive nutrition

education and guidance. A personal food plan incorporates both physiological requirements and personal needs and uses community resources as indicated."

It is clear from study after study including those conducted by Congress and the Government Accounting Office the WIC program provides services in all areas discussed above.

The problem of low birthweight is not alone as a cause of infant mortality. The problems as defined by the Childrens Defense Fund include:

- Two-thirds of all infant deaths occur in babies weighing less than 5.5 pounds at birth in the U.S. and 70 percent in Illinois.
- Low birthweight is sometimes associated with increased occurrence of mental retardation, birth defects, development and growth problems, blindness, autism, cerebral palsy and epilepsy.
- Maternal factors associated with low birthweight infants include: lack of prenatal care; poor nutrition; smoking, alcohol and drug abuse; age of

mother (especially youth of mother); social and economic background; and marital status.

- Expectant mothers who do not receive prenatal care are three times as likely to have a low birthweight baby.
- About 70 percent of expectant mothers under age 15 receive no care during the first months of pregnancy and 25 percent of their babies are born prematurely.
- Infant mortality is nearly twice as high for Blacks as Whites, and prematurity and low birthweight are almost twice as common for Blacks and some other minorities.
- Unmarried women are twice as likely to have low birthweight infants, partly because of lack of adequate prenatal care.

Of those problems I have identified, most, if not all, are poverty related. Although many of the problems are addressed by WIC, this program alone cannot solve all poverty related problems.

I have concentrated my remarks today on low birthweight as a cause, often created by poverty, and its relation to infant mortality. I do wish to conclude with a list of specifics that require much greater study by the Committee in

attempting to fully address this critical problem:

1) Increased allocation to WIC.
2) Reaching women early in pregnancy and improving their use of medical and social services in the community.
3) Reducing practices harmful to the fetus--smoking, use of alcohol and drugs--and improving the nutrition practices of pregnant women.
4) Identifying high-risk pregnant women who might deliver preterm or bear an infant too small for its gestational age.
5) Tailoring prenatal services for high-risk women to reduce the incidence of preterm delivery and low birthjweight infants.
6) Expansion of teen pregnancy prevention programs.
7) Pregnancy-Food Stamp Outreach program establishment.
8) Increased allocation for Planned Parenthood.
9) Increased allocation to the Community Services Block Grant, Community Food and Nutrition Program, with a prenatal nutrition direction.
10) Increased allocation to Maternal and Child Health Block Grant.
11) Expanded usage of community based prenatal programs

including those offered by community action agencies.

12) Creation of a National Task Force on Infant Mortality with membership beyond the medical profession, including community leaders, sociologists, and the high-risk population themselves.

13) Increase available medical care to all poor.

14) Guarantee nutritional basics for all Americans.

In Springfield alone, we have many fine programs that deserve a greater revenue base. To name a few, Planned Parenthood, Parents Too Soon, The Care Center, Springfield Urban League WIC and the Male Responsibility Program, and the Springfield Department of Public Health. Outreach, education, basic services, financial/nutritional support are but a few areas of need.

Members of Congress, and all Americans should be appalled, as I am. Can we be the "moral leaders of the free world," as noted by President Reagan, and allow our babies to die, often starved to death in the womb! We must not allow this tragic condition to proliferate. Let's join together to address infant mortality. Justice and equality are not issues that begin with birth and life, but are to be provided to all

Americans, and this must begin with guaranteed prenatal nutrition and adequate health care for all.

Thank you!

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All bibliographic and footnote data will be provided upon request.

PREPARED STATEMENT OF JULIA SUTTON, CRNA, SPRINGFIELD, IL

I. The need for more professional OB staff - doctors, midwifery

A. Medical education funding tied to repayment with service in these needy areas.

1. This has several positive advantages:

a. Provides immediate increase in health-care providers to the areas most in need

b. Enables persons of ability and interest who would otherwise not be able to obtain necessary education to enter the OB-GYN field.

B. Work out a program of mini-internships through [illegible] and local [illegible] with added immediate input and feedback professionals on a rotation basis to the areas involved.

C. Involve midwifery possibly for home care route prenatally.

II. Nutritional Care to help reduce low birthweight infants and their suffering effects of poor nutritional regimen.

A. Rather than any sweeping changes to be used in exchange for food set up a food-assistance program utilizing our overabundance of grain and dairy products in addition to the stamps.

Many times the stamps are not used for good basic food products and the above suggestion would increase the likelihood of better nutrition while having the added benefit of aiding our agricultural community.

III. Require reporting of pregnancy by aid patients so information and help in obtaining care can be entrusted early in the pregnancy. The need is obvious, as well as the results if ignored.

IV Increase programs presented on pregnancy to school children in Junior High as well as High School levels.

V Determine if a work-care group of retired physicians and nurses could be organized to help provide care or to help find solutions to the infant mortality problem.

VI Address the issue of malpractice insurance costs and ceilings on legal awards — this has already affected the number of qualified professionals able to offer their services in the S-IFH area and will continue to increase the outlook to a crisis situation unless the problem is addressed.

VII Utilize media to inform the public of the extent of the problem, the solutions available and the cost effectiveness of prevention versus costs now incurred by addressing the results of poor prevention measures through good prenatal care.

Thank you.

Sincerely,

Mrs Julia Sutton, CRNA
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